



Nevada's Injury Data Surveillance Project

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Introduction

The Injury Prevention Program has conducted a Statewide Data Surveillance Project as part of a plan to identify the magnitude of the injury problem in Nevada. Data can be used to show how many people are injured each year and how many of those people die or suffer permanent disabilities as a result of their injuries. Data compared from year to year can give an indication of how injuries are affecting Nevada's citizens and whether or not a specific injury is affecting more of a particular area or population. Information such as this is invaluable in terms of letting communities know where efforts would be best placed to prevent these injuries, as well as letting them know if a prevention effort has or has not been effective. An update of this report is anticipated to be conducted in the year 2004.

According to the Centers for Disease Control and Prevention (CDC), throughout history, intentional and unintentional injuries have been the major cause of premature death. The National Committee for Injury Prevention and Control (NCIPC) defines an injury as: "Any intentional or unintentional damage to the body resulting from acute exposure to thermal, mechanical, electrical, or chemical energy or from the absence of such essentials as heat or oxygen."

This includes the following focus areas:

- Alcohol in motor vehicle injuries
- Bicycle injuries
- Drowning/submersion injuries
- Fall injuries
- Fire and burn injuries
- Firearm injuries
- Homicide

- Motor vehicle injuries
- Pedestrian injuries
- Poisonings
- Spinal cord injuries
- Suicide
- Traumatic brain injuries
- Violence against women

In modern America, injury takes a high toll on the lives of our citizens and is the leading killer of our children, teenagers, and young adults.¹ Nearly 19,000 children and teenagers under the age of 20 died from injuries in the United States (U.S.) in 1997. In 1997, 146,400 persons of all ages died in the U.S. from injuries due to a variety of causes such as motor vehicle crashes, firearms, poisonings, suffocations, falls, fires and drowning accidents. Of these, 92,353 persons died as a result of unintentional injuries. The number of injuries that did not result in death is not available at this time.¹

From 1991-2000, 9,729 Nevadans died as a result of injuries. Of these 9,729 injury deaths, 5,249 were unintentional and 4,480 were intentional. These statistics include the young and the elderly alike. Injury has no prejudice; it affects all ages, races, religions, and genders.

In order to address injury prevention in Nevada, the NSHD has conducted this Data Surveillance Project. Surveillance of injuries is the capacity for tracking and monitoring the incidence rates, causes, and circumstances resulting in fatal and non-fatal injuries.² Data is the factual information (as measurements or statistics) used as a basis for reasoning, discussion, or calculation. Both

¹National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

¹ National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

² Christoffel, Tom, Gallagher, Susan Scavo. *Injury Prevention and Public Health*. Maryland: Aspen Publishers Incorporated; 1999.

surveillance and data are critical to this initiative. This process will help to ensure available resources are targeted, and duplications are avoided. This project assesses injury occurrences and data in Nevada. It provides data and assessment findings, which identify community and state needs, and serves as a basis for program planning and coordination with injury prevention activities statewide.

Progress in preventing injuries that plague our state depends, in part, on the availability of objective and reliable information on the magnitude and characteristics of the problem. Nevada will use this Data Surveillance Project to assess the need for new policies or programs and to evaluate the effectiveness of existing policies and programs. This collection of data will allow Nevada to have a comprehensive understanding of the impact injuries have on the community.

Goals

The goals of the Injury Prevention Program are to reduce injuries, disabilities, and death due to intentional and unintentional injuries by helping Nevadans remain:

- Safe at home from injuries resulting from fires, falls, poisonings, drowning accidents, child abuse, and domestic violence.
- Safe on the streets and highways from injuries caused by motor vehicle, bicycle, and motorcycle crashes as well as injuries sustained by pedestrians.
- Safe at school from injuries sustained on the playground, while playing sports, and as a result of youth violence.
- Safe at work from injuries related to environmental hazards, equipment, and working conditions.

- Safe in the community from intentional injuries such as self-inflicted and assaults, and from unintentional injuries caused by falls, fires, and drowning in public places.¹
- Safety in the community also involves prompt and appropriate responses from emergency medical systems, emergency operators and dispatchers, poison control centers, and trauma care systems when injuries do occur.²

Data surveillance is a critical first step in addressing any public health problem. One important lesson learned about data surveillance in public health is that surveillance improves as better measures are developed, and the patterns behind the problem become clearer with time. Data surveillance, itself, assists in reaching the goal of prevention because it aids in the concentration of efforts and allows a successful guide of information to be available for our community. In this way, data surveillance will help Nevada build momentum for achieving the Injury Prevention Program's goals.

Economic Burden of Injury

Only in recent years has much been done to develop cost information on injury. In the words of a 1989 report to Congress on the cost of injury in the United States:

For the 57 million persons injured in 1985, the cost amounted to \$157.6 billion, or \$2,772 per injured person. Direct expenditures for hospital and nursing home care and physician services amounted to \$44.8 billion or \$790 per injured person.

The direct cost is only the beginning. Disability from injury also results in loss of output. This results in more than 5 million life years of losses, which

¹ Centers for Disease Control and Prevention, <http://www.cdc.gov/safeusa> (September 2002).

² National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

amounts to nine years per 100 injured persons, valued at \$64.9 billion. The morbidity costs amount to \$1,145 per injured person. Other losses result from premature injury fatalities.

Approximately 143,000 premature deaths from injury occurred in 1985 and an additional 13,000 deaths occurred in later years due to injury amounting to an estimated annual loss of 5.3 million life years, or 34 years per death. The loss to the economy amounts to \$47.9 billion at a 6% discount rate, or \$307,636 per death.¹

This report to Congress can now be seen as an underestimate of injury costs. By the mid 1990's the estimated cost of injury had risen to more than \$224 billion, a 42% increase in a decade.¹ Public sources (federal, state, and local) pay about 28% of this cost.¹ Nevada has no complete data available regarding the actual costs injuries have on the state at this time.

¹ Christoffel, Tom, Gallagher, Susan Scavo. *Injury Prevention and Public Health*. Maryland: Aspen Publishers Incorporated; 1999.

² Christoffel, Tom, Gallagher, Susan Scavo. *Injury Prevention and Public Health*. Maryland: Aspen Publishers Incorporated; 1999.

Data for Injury Prevention

Data for Injury Prevention

Many Nevadans don't understand the magnitude of the injury problem in this state. Data can be used to show how many people are injured each year and how many of those people die or suffer permanent disabilities as a result of their injuries. Data compared from year to year can give an indication of how injuries are affecting Nevada's citizens and whether or not a specific injury is affecting more of a particular area or population. Information such as this is invaluable in terms of letting communities know where efforts would be best placed to prevent these injuries, as well as letting them know if a prevention effort has or has not been effective. For this Data Surveillance Report, injury data was collected from a number of sources. Listed below are the sources this report was generated from. For more information on these specific databases, contact the NSHD's Bureau of Health Planning and Statistics at <http://health2k.state.nv.us>.

Center for Health Data and Research

The Center for Health Data and Research is designed to facilitate the collection, storage, maintenance validation, statistical analysis, display and dissemination of health and related data to support the overall mission of the NSHD. <http://health2k.state.nv.us/nihds/center.htm>

The National Center for Health Statistics

The National Center for Health Statistics (NCHS) is responsible for the Nation's official vital statistics. These vital statistics are provided through state-operated registration systems. Nevada has its own system. The registrations of

vital events such as births, deaths, marriages, divorces and fetal deaths in Nevada are filed with the Office of Vital Records as required by law. This information is generally of high quality and is verified and coded to provide information on both the etiology and the nature of the injury and on victim age and gender. Injury deaths are coded using the external cause of injury codes from the International Classification of Disease Codes (ICD-9, ICD-10).

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS), one of the world's largest telephone surveys, tracks health risks in the United States. Information from the survey is used to improve the health of its citizens. Injury-related data in BRFSS includes smoke alarm use and seatbelt use modules that can be analyzed by gender, age, race/ethnicity, income level, and education. Two questions regarding Injury Prevention, along with percentage results have been included in this report on page number 51. For more information on this report log on to the NSHD's Bureau of Health Planning and Statistics web site at <http://health2k.state.nv.us>.

Trauma Registry

The State of Nevada Trauma Registry (TR) managed by the NSHD, Bureau of Health Planning and Statistics contains data on trauma occurrences within the State of Nevada as outlined in Nevada Administrative Code 450B. Data is collected either manually or through electronic data collection and data submission methodology utilizing the National Trauma Registry of the American

College of Surgeons (TRACS). The data in this database reflects only Washoe Medical Center information. Data from University Medical Center and other hospitals in the state were not available at the time when this report was published. ** Caution should be used when interpreting these numbers.

For more information on this database log on to the NSHD's Bureau of Health Planning and Statistics web site at <http://health2k.state.nv.us>.

Fatality Analysis Reporting System

The National Highway Traffic Safety Administration manages the Fatality Analysis Reporting System (FARS). FARS contains data on all fatal traffic crashes within the 50 United States, the District of Columbia, and Puerto Rico. The data system was conceived, designed, and developed by the National Center for Statistics and Analysis (NCSA) to assist the traffic safety community in identifying traffic safety problems, developing and implementing vehicle and driver countermeasures, and evaluating motor vehicle safety standards and highway safety initiatives. This system is a valuable source for Motor Vehicle Crash (MVC) data. This database tracks injury and alcohol related MV crash information. For more information log on to the National Highway Traffic Safety's website at <http://www.nhtsa.dot.gov>.

Hospital Discharge (In-Patient) Data (UB92)

The Hospital Discharge Data (HDD) was provided by the Center for Health Information & Analysis (CHIA) at the University of Nevada, Las Vegas. CHIA helps compile the hospital discharge data from all hospitals throughout the state. Hospital discharge records include the dollar amount of charges associated with

that admission. This includes fees for daily hospital services, ancillary services, and any other services defined as patient care. These charges do not include professional fees, including physician fees. Charges represent bills generated, not the actual cost to the hospital or revenues collected (** All charge data in this Data Surveillance Project are underestimates by virtue of missing charges and external codes). The Center for Health Data and Research performed a study on the reporting of e-coded injuries in inpatient hospital discharge data in 2000. In that study it was found that Nevada discharge data contained approximately 64.7% of the e-coded injuries that were expected. This study was performed by using Utah's hospital discharge and mortality data as a control source along with Nevada's mortality data from 1995 to 1999 to create discharge estimates. A further review of the inpatient data after the results of this study were established found that the problem varied greatly from hospital to hospital. For example a major hospital in Clark County that handles much more than 15,000 patients a year reported five or less e-coded admissions per year from 1998 to 2001. Some hospitals also showed fluctuation in how often e-coded injuries were reported from year to year. That was evident by another major hospital in Clark County, also serving much more than 15,000 patients a year, having the rate of admissions with e-codes go from 13% in 1998 all the way down to 4% in 2001. For more information on this database, log on to the Center for Health Information & Analysis' CHIA's website at the University of Nevada, Las Vegas. http://www.unlv.edu/Research_Centers/chia/.

Toxic Exposure Surveillance System

Toxic Exposure Surveillance System (TESS) is a comprehensive poisoning surveillance database in the United States. TESS is a valuable tool to collect poisoning injury information. TESS contains detailed toxicological information on more than 24 million poison exposures reported to U.S. poison centers. This database is used to track poisonings in Nevada. For more information on this database log on to the TESS's website at <http://www.aapcc.org/poison1.htm>.

Youth Risk Behavior Survey

The Youth Risk Behavior Survey (YRBS) reports health-risk behaviors among Nevada's middle and high school students. In the spring of 2001, the Nevada Department of Education conducted its fifth statewide administration of the YRBS as part of the CDC's YRBS. The CDC uses this epidemiological surveillance system to measure the prevalence of six priority health-risk behaviors among youth, and to monitor progress toward achieving relevant national health objectives for the year 2010.

Behaviors and perceptions related to personal safety were the topic of thirteen questions on the middle school survey and of eleven questions on the high school survey. Some of these questions measured the frequency with which students engage in behaviors related to unintentional injuries, such as not wearing seat belts or helmets and riding in a car with a driver who had been drinking alcohol. Seat belt use, for example, is estimated to reduce the risk of fatal motor vehicle injury by 45% and moderate to critical injuries by 50%.¹ Similarly, bicycle helmets substantially reduce the risk for serious head injuries

¹ National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

during bicycle-related crashes and bicyclist involved in motor vehicle crash injuries, approximately 30% of which involve alcohol, are the leading cause of death among youth age 15-24 in the United States.¹

The personal safety section also dealt with how often students feel safe and accepted; whether they had missed school because of safety concerns; and if they had ever belonged to a gang or participated in perceived gang activity at their school.

The YRBS is one of the very few sources in Nevada for reliable statistics related to behaviors that result in unintentional and intentional injuries for middle and high school students. Agencies, organizations and individuals who address the health of children and youth are strongly encouraged by the Nevada Department of Education to use the survey data in their decision making processes to support and develop appropriate and effective programs focused on the health risk behaviors practiced by children and youth and identified by the data as having the potential for resulting in serious negative health consequences.

The questions in the 2001 survey focused on the six-priority health risk behaviors established by the CDC in 1998 that resulted in the most significant morbidity, mortality, disability and social problems during youth and into adulthood. These include:

- Behaviors that result in unintentional and intentional injuries.
- Tobacco use.

¹ National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

- Alcohol and other drug use.
- Sexual behaviors that result in Human Immunodeficiency Virus (HIV) infection, other sexually transmitted diseases (STD's) and unintended pregnancies.
- Dietary Behaviors.
- Physical Activity.

2001 was the first year that all seventeen school districts in Nevada participated in the survey. The resulting data provides a baseline for future comparisons. The sampling and administration procedures used ensure that the statewide data are representative of Nevada middle school (13 questions) and high school (11 questions) students. A total of 2,214 students in 62 Nevada public schools containing grades 9, 10, 11, 12 were selected for participation in the 99-item, multiple choice high school YRBS. The school response rate was 95% and the student response rate, based on 1,464 usable answer sheets received from the sampled students, was 66%. The middle school sample included 11,486 students from 183 schools containing grades 6, 7 and 8 who responded to the 78-item middle school YRBS. A random sample of 7,827 surveys was drawn from these available district-level surveys to ensure that the final sample provided proportional representation of each of the state's 17 school districts. Survey administration procedures were designed to help protect the privacy and confidentiality of all participating students. Student participation was voluntary, and parent permission (active or passive) was obtained.

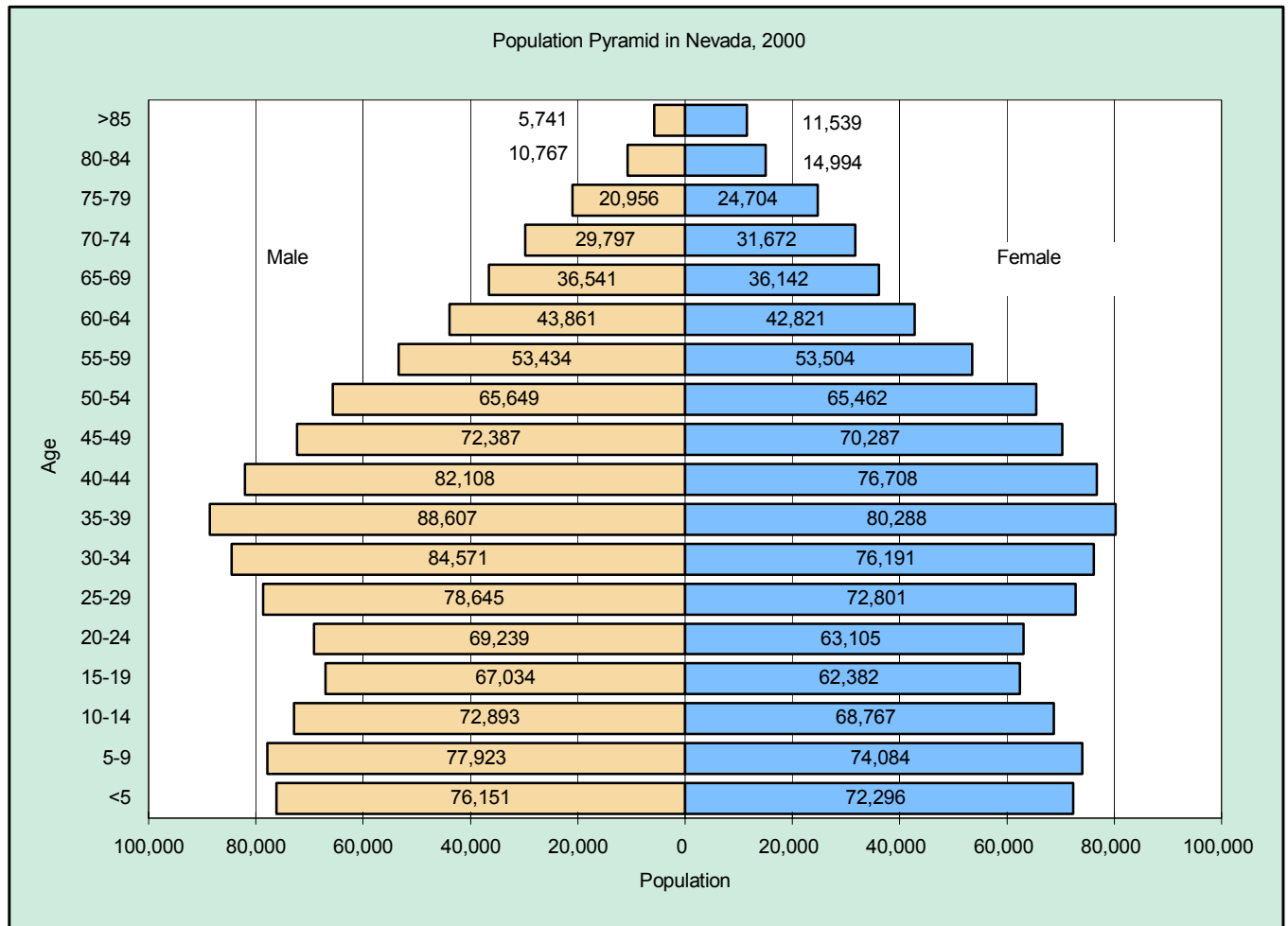
The next biennial YRBS is scheduled to be administered in the spring of 2003. If you have any questions about the survey or would like a complete copy, call the Nevada Department of Education at, (775) 687- 9173. Twenty-four questions, regarding injury prevention, along with percentage results from the spring 2001 YRBS, have been included in this report on page #52.

Web-based Injury Statistics Query and Reporting System

Web- based Injury Statistics Query and Reporting System (WISQRS) is an interactive database that allows easy access to national and statewide injury mortality data. It provides relevant statistics and information on different injuries, including intentional and unintentional injuries. This database is useful for research and for making informed public health decisions. This web page is produced by the CDC. To access this web page go to www.cdc.gov

Injuries in Nevada

Nevada's Population



Nevada's population from 1990 to 2000, was by far the fastest growing state in the nation, and Las Vegas was the fastest growing metropolitan area in both Nevada and the nation. The 1990 Nevada population of 1,236,130 grew by over 64% to 2,034,050 in 2000 and is projected to surpass 2,750,000 by 2005. The vast majority of growth has been by in-migration. The Las Vegas and Reno metropolitan areas contain more than four out of every five (86%) of the state's residents.¹

¹ Nevada Vital Statistics Report 2000. Nevada State Health Division (NSHD).

Motor Vehicle Injuries

Many injuries from motor vehicle crashes (MVC) are preventable. Some approaches to measure the level of MVC related injuries are by deaths and hospital admissions.

A total of 3,013 Nevada residents died from MVC from 1990 to 2000, 266 of them in 2000. Male victims accounted for approximately two-thirds of the deaths. The age groups 75-84, and over 85 had the highest death rates at 27.4 and 33.5 per 100,000 population, respectively.

In 1999 HDD revealed that 1,072 inpatients were discharged from the hospitals as a result of a MVC injury. The average total charge in 1999 for MVC injury was \$31,100.00 (** See HDD on pgs. # 10, 38)

From 1999 to 2000, 1,221 and 1,249 trauma patients were reported respectively from the TR. In those two years, 32% of the patients did not use any kind of safety restraints when the accidents occurred. Patients between the ages of 15 and 24 made up 28% of the patients; 13% of patients were from California. (See Tables pgs. # 44, 54, See Graphs pgs. # 58, 59, 60)

Alcohol Related Motor Vehicle Related Injuries

Alcohol related MVC injuries cost United States taxpayers about \$15 billion per year. Alcohol related impairment is a major factor in approximately one-half of all fatal traffic collisions in the United States.¹ A 12-ounce can of beer, a 5-ounce glass of wine and a 1.5-ounce shot of straight 80 proof liquor all have

¹ National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

equal amounts of alcohol¹. It is well established that drinking alcohol drastically affects a driver's ability to see and react to road conditions. In Nevada, it is illegal to drive with a blood alcohol concentration (BAC) of .10 percent or more.

Data from FARS showed that in Nevada, from 1994 to 2000, the overall number of drivers who were involved in a MVC, driving under the influence of alcohol (BAC .10+), decreased from 34% to 31% respectively. Compared to national statistics, Nevada's 31% of MVC that involved alcohol was higher than the 24% national rate. Data in 2000 also shows that from midnight to 2:59 a.m. in Nevada, 75% of the fatal crashes were alcohol related.

TR data shows, in 1999, 18.4% (n=225) of patients injured from MVC had BAC of .10% or above. The numbers decreased to 10.6% (n=133) in 2000. From 1999 to 2000, 35% of the MVC patients were discharged home, 5.6% were discharged to jail, 8.7% went to a rehabilitation center, 4.7% died, and 54% were unaccounted for. (See Table pg. # 53)

The Nevada Department of Education's (NDOE) YRBS provides state and city specific estimates of behavioral risks among adolescents in Nevada. In spring 2001, the following statistics were found relating to youth injury in correlation to alcohol in Nevada. The survey showed that 29.9 % of Nevada high school students during the past 30 days, had ridden in a car or other vehicles driven by someone who had been drinking alcohol. The survey also showed that 13.2% of Nevada high school students during the past 30 days had driven a car

¹ Christoffel, Tom, Gallagher, Susan Scavo. *Injury Prevention and Public Health*. Maryland: Aspen Publishers Incorporated; 1999.

or other vehicle when they had been drinking alcohol. (See Spring 2001 YRBS report on page #52)

Seat Belt/Safety Restraint Use

Seat belts and safety restraints are effective ways to reduce fatalities and injuries in traffic accidents. These devices have saved thousands of lives each year in the United States.¹ All states have a primary enforcement child safety seat law. Nevada has secondary enforcement seat belt laws in addition to its child safety seat law.

The 1997 BRFSS shows 11.5 % of Nevadans responded that they did not wear their seat belts when driving or riding in a car. This result was lower than the 14.8% reported in the 1995 BRFSS. In 1997, 3.8% of Nevadans responded that the child who was under the age of 16 in their household did not use appropriate restraints when riding in a car. The result was lower than the 7.5% reported in the 1995 BRFSS.

Data in 2000 from FARS indicated that 34.6% of drivers of passenger cars and light trucks involved in fatal crashes in Nevada did not use any kind of safety restraints. This percentage is slightly better than the U.S. statistic of 35.4%.

In the Spring 2001 survey, the following statistics were found to be related to injury prevention in Nevada: 68% of Nevada high school students reported wearing their seat belt “most of the time” or “always” when riding in a car, the

¹ National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

other 32% reported wearing their seat belts “sometimes, seldom, or never.” (See Spring 2001 YRBS report on page #52)

Homicide/Assault Injuries

According to the National Crime Index Report of 2000, homicide/assault injuries are among the most frequently addressed topics in the study of crime.

The number of deaths due to homicide or assault for Nevada residents decreased from 202 in 1996 to 128 in 2000, representing a 36% decrease. Males in 2000 were five times more likely to die from homicide or an assault related injury than their female counterparts. At least 62% of the homicides from 1990 to 2000 were committed with a firearm, a total of 1,117 deaths. Of these 1,117 deaths, 395 involved handguns.

With regard to age, the 15 to 24 year old age group was most affected by homicides. From 1990 to 2000, this age group had the highest death rate at 19.7 per 100,000 population.

HDD showed there were 346 patients admitted to Nevada hospitals for an assault related injury in 1999. The average cost for these patients was \$19,720.62 and the average length of stay in the hospital was 4.38 days. (See HDD on pgs. # 10, 38)

The TR showed assault injuries to patients increased from 121 in 1999 to 159 in 2000, a 31% increase. From 1999 to 2000, 35% of the assault injuries occurred at home. Twenty eight percent of these same assault injuries occurred on streets or highways, while 14% occurred in public buildings. Forty one percent of the assault injuries were committed by cutting and piercing

instruments, and 22% were by firearms. It is important to remember that many assault injuries, including injuries in general are very underreported.

In the Spring 2001 YRBS, the following statistics apply to assault in Nevada. Nearly 9% (8.8%) of Nevada high school students, and middle school students reported that during the past 12 months, they had been threatened or injured with a weapon such as a gun, knife, or club on school property. (See Spring 2001 YRBS report on page #52), (See Tables pgs. # 44, 54 See Graphs pgs. # 61, 62, 63, 64)

Suicide/Self-Inflicted Injuries

Suicide is death from intentionally self-inflicted injury. Suicide is the cause of 21% of all injury deaths and has become the ninth leading cause of death in the United States and the fifth leading cause of premature death.¹ Suicidal behavior is most often related to mental disorders such as depression or drug and substance abuse, but this is not always true. Recently researchers have identified some major factors that place individuals at higher risk for suicide. These factors include mental illness, substance abuse, previous suicide attempts, family history of suicide, history of sexual abuse, and impulsive or aggressive tendencies.²

¹ National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

² Christoffel, Tom, Gallagher, Susan Scavo. *Injury Prevention and Public Health*. Maryland: Aspen Publishers Incorporated; 1999.

The most common method of committing suicide is by use of a firearm. Males are four times more likely to succeed in a suicide attempt, however women attempt suicide more often during their lives than do men.¹

Nevada has the highest suicide rate in the U.S. at 10.7, almost twice the national average at 21.3.² Deaths from suicide in Nevada increased from 294 in 1990 to 388 in 2000, a 32% increase. Suicide was the seventh leading cause of death in Nevada in 1998, and was the second leading cause of death for Nevadans between the ages of 10 to 34 in the same year. In 2000, males were about five times more likely than the females to commit suicide. In the year 2000, 320 of Nevada's suicide victims were men and 68 were women. The most common method from 1990 to 2000 for committing suicide in Nevada was the use of a firearms or explosives. Sixty eight percent of firearm injury deaths in Nevada were suicides. During that time, 2,639 Nevadans used a firearm or explosive to commit suicide. The second most common method for committing suicide in Nevada between 1990- 2000 was the use of a poisonous substance; 690 suicides were committed through this mode of behavior. The third most common suicidal method from 1990 to 2000 in Nevada at 457 deaths, was by hanging, strangulation, and suffocation.

HDD from 1999 revealed that 583 patients were admitted to a hospital based on a self-reported suicide attempt or self-inflicted injury. The average cost for these admitted patients was \$12,067 per patient, and their average hospital stay was 6.05 days in 1999. (** See HDD on pgs. # 10, 38)

¹ National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

² American Association of Suicidology, www.suicidology.org; 2002.

From 1999 to 2000, TR data for the state of Nevada indicated that 85 patients were admitted due to a self-inflicted injury. Of the 85 persons admitted, 16% were discharged to their home, 13% were discharged to an acute care hospital, 11% were discharged to a mental institution, 8% died, and 52% were unaccounted for.

In the Spring 2001 YRBS, the following statistics applied to suicide related injuries in Nevada. During the past 12 months, 19.6% of Nevada's high school students and 16% of Nevada's middle school students reported, they had seriously considered attempting suicide. During the past 12 months, 10.7% of Nevada's high school students and 11.9% of Nevada's middle school students reported, they had actually attempted suicide one or more times. (See Spring 2001 YRBS report on page #52), (See Tables pgs. # 45, 54, See Graphs, pgs. # 65, 66, 67, 68)

Firearm Injuries

"Firearm" is a generic term that encompasses all guns. In recent years significant progress has been made to increase the quality and quantity of information about firearm injuries, but much needs to be done. According to the CDC, in the year 2000 there were 28,663 firearm related deaths in the US.

Reducing the risk of this particular injury involves enforcing laws against illegal possession of firearms, sales of firearm to persons without proper identification and a complete background check information, educating the public

as to the proper use of firearms; especially children and adolescents, and holding individuals responsible for harm caused as a result of using a firearm¹.

In 2000, 329 Nevada residents died as a result of a firearm related injury. This number has decreased 17% since 1995 when the number of firearm related deaths was 397. Males were 7 times more likely to die of a firearm related injury in 2000 compared to females. From 1990 to 2000, 68% of firearm injury deaths in Nevada were suicides. Among the suicide deaths (2,633) by firearm, over half were committed with a handgun. From 1990 to 2000, 28.7% of the firearm related injury deaths were homicides and among these 1,117 deaths as a result of a homicide, 34% were from a handgun discharge.

1999 HDD shows 93 patients admitted to the hospital were due to firearm related injury. The average cost of these 93 patients was \$15,634, while the average length of stay was 5.45 days. (**See HDD on pgs. # 10, 38)

From 1999 to 2000, 210 trauma patients were admitted to the hospital, due to firearm use as reported in the TR. Of these 210 injuries, 50% of the were sustained at home, 41% involved a handgun, 20% resulted in the death of the patient, and 41% resulted in the patient being discharged to their home. (See Tables pgs. # 45, 55, See Graphs pgs. # 69, 70, 71, 72)

Traumatic Brain Injuries

Traumatic Brain Injury (TBI) is an injury to the brain caused by an external physical force that may produce an altered state of consciousness in the

¹ Christoffel, Tom, Gallagher, Susan Scavo. *Injury Prevention and Public Health*. Maryland: Aspen Publishers Incorporated; 1999.

individuals affected.¹ As a result, patients may have impaired cognitive abilities, behaviors, emotional or physical functioning. The CDC estimates the following statistics apply to TBIs in the United States each year (based on 1995-1996 data):

- 1 million people are treated and released from hospital emergency room departments.
- 230,000 people are hospitalized and survive their injury.
- 50,000 people die due to their injuries.

HDD from 1999 shows 1,775 patients were discharged from the hospital with TBIs. The average hospital cost of these patients was \$33,824.00 the second highest cost among all injuries. The average hospital stay length for these TBI patients was 6.47 days.

Of the 1,802 TBIs reported in the TR from 1999 to 2000, 53% occurred on a street or a highway. Twelve percent of these TBIs reported occurred in a place for recreation or sport activities, while another 12% occurred at home, and 23% were unaccounted for. Twenty three percent of the TBI patients reported in the TR between 1999 and 2000 died. Forty percent of the patients were discharged home, while 18% were discharged from the hospital to a rehabilitation center, and 19% were unaccounted for. (See Table pg. # 56)

Unintentional Fire and Burn Injuries

¹ National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

Every year, millions of people in the United States suffer from burns. Thousands die as a result of their burns, and many require long-term hospitalization. From 1990 to 2000, 194 Nevada residents died from fire and burn related injuries. Of these 194 injuries, 18% were persons under the age of four, 51% were age 5-64, while 31% were persons aged 65 years and older.

1999 HDD shows, 71 patients were discharged due to a burn injuries, with an average cost of \$17,313.00 and an average hospital stay of 6.89 days.
(** See HDD on pgs. # 10, 38)

Of the 37 unintentional fire and burn traumatic injuries in the TR, from 1999 to 2000, 20% were injured due to ignitions of a highly flammable material, 54% were injured at their home, and 26% were unaccounted for.

The BRFSS data from 1999 showed that 7.8% of people in Nevada did not have a smoke alarm at home, an increase from 1997 when the report showed 2.5% of Nevadans indicated that they did not have a smoke alarm at their home. Compared to the United States statistic of 3.9% in 1999, Nevada was much higher. In 1999, 29.7% of persons who had less than a high school education responded that they did not have smoke alarms at their home, which was the highest rate of any education group. (See Tables pgs. # 46, 55, See Graphs pgs. # 73, 74, 75, 76)

Drowning/Submersions

The data on circumstances surrounding drowning is rather limited, as compared to other types of injury; however, roughly one fifth of drownings in the U.S. are related to boating, swimming pools and bathtubs accounting for 60%

and 25% are by unidentified means. Alcohol is assumed to be involved in as many as half of all drownings. Drowning rates have decreased considerably since 1930, although the reasons for this are unclear.¹

In Nevada between 1994 through 2001, 172 reported drownings have ended in fatalities, in the 5 and over age group. Between 1994 and 2001 in the 4 and under age group 71 reported drownings have ended in fatalities. (See Tables pgs. # 46, 47)

Traumatic Spinal Cord Injuries

Damage to the spinal cord can occur due to a traumatic injury. In most traumatic spinal cord injuries (TSCI), the backbone pinches the spinal cord, causing it to become bruised, swollen, or severed. Approximately 11,000 people in the U.S. sustain a TSCI each year. Most of them are injured in auto, sports accidents, falls, and industrial mishaps.¹ The injuries can result in a total loss of movement and sensation below the injury.

Nevada's HDD showed that 121 inpatients were discharged in 1999 due to TSCIs. The average cost of these injuries was \$76,370, the highest among all the reported injuries and twice the average cost of TBIs. TSCIs had the highest average hospital stay length. In 1999, the average length of stay for a TSCI was 12.54 days compared to 6.9 days for TBI. (**See HDD on pgs. # 10, 38)

In the TR, there were 126 TSCIs from 1999 to 2000. Over half of these injuries came from motor vehicle crashes. Another 40% of these injuries came

¹ National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

from falls. 62% of the 126 patients injured were sent to a rehabilitation center, 23% were discharged to their home and 15% died. With regard to age, the group between the ages of 25 and 44 represented over 50% of the total patients (n=126). 42% of these patients, who were Nevada residents, were injured in California. (See Table pg. # 56)

Unintentional Fall Injuries

Every hour an older adult (65 or older) dies as the result of a fall. In 1998, more than 9,600 persons 65 and older died from fall-related injuries, making falls the leading cause of injury death among this age group. Hip fractures are among the most serious fall-related injuries. Half of older adults who suffer a hip fracture never regain their previous level of functioning, and many are unable to live independently after their injury. Approximately 300,000 older adults suffer fall-related hip fracture each year. In 1994, the estimated cost of fall-related injuries was \$20.2 billion. By 2020, the CDC predicts the cost may reach \$32.4 billion annually.¹

From 1990 to 2000, there were 592 deaths related to falls in Nevada. Of these 592 deaths, 65% were persons aged 65 years and older. Death rates for falls increased with age. The death rates were 2.2, 7.9, 26.2 and 104.9 for the age groups 55-64, 65-74, 75-84, and 85+, respectively.

In 1999 HDD showed that 2,513 patients were discharged from Nevada hospitals due to fall injuries. The average cost for fall injuries was \$19,841.03 and the average length of stay was 5.1 days. (** See HDD on pgs. # 10, 38)

¹ National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

In the TR, 657 patients were injured from falls from 1999 to 2000. Of these 657 patients, 42% occurred at home and 28% at a place for recreation and sports, and 30% were unaccounted for, respectively. The age group most affected was the 15 to 24 years olds at 21.3% of the total patients admitted. Of the 657 patients, 44.7% were discharged home, while 9% went to a rehabilitation center after being discharged from the hospital, and 46.3% were unaccounted for, respectively. (See Tables pgs. # 47, 56, See Graphs pgs. # 77, 78, 79, 80)

Unintentional Poisonings

Poison exposure is a leading cause of childhood injury in the United States. Most poisonings are unintentional. Common household items such as cleaning products, medicine, and cosmetics account for the majority of poisonings at home.

From 1990 to 2000, 815 Nevadans died due to an unintentional poisoning. The death rate for unintentional poisonings increased 3 fold from 3.1 per 100,000 population in 1990 to 9.0 per 100,000 population in 2000. Of the 815 deaths, 42% were persons between the ages of 35 and 44. Male deaths due to unintentional poisoning were approximately 2 times more likely to occur than female deaths from the same cause.

In 1999 HDD showed that 344 patients were discharged from the hospital in relation to unintentional poisonings. The average cost of this particular injury was \$12,850.50, and the average hospital length of stay was 3.45 days. (**See HDD on pgs. # 10, 38)

TESS data from January 2001 through October 2001, showed that over 50% of all exposures to a toxic substance occurred in children age 5 and under

in Nevada. The leading poisonous substances in poisoning of children who were age 5 and under were cosmetic or personal care products. The second leading poisonous substance was cleaning substances, or household cleaning supplies, followed by analgesics. The northern part of Nevada is serviced by the Oregon Poison Center- Emergency phone # is, 1-800-452-7165, and the Southern part of the state is serviced by the Rocky Mountain Poison & Drug Center- Emergency phone # is, 1-800-332-3073 (See Tables pgs. # 48, 49, 55, See Graphs pg. # 80, 81, 82, 83)

Bicycle Injuries

Each year in the United States, more than 500,000 people are nonfatally injured while riding bicycles.¹ In 1999, 750 bicyclists died in crashes. More than one-quarter were children ages 5-15. More than 95% of bicyclists killed were not wearing helmets. An estimated 140,000 children are treated each year in emergency departments for head injuries sustained while bicycling.

In Nevada between 1997-1999 there were a total 21 bicycle fatalities. There are a number of locations at which fatalities were reported. Approximately 56% of the bicycle fatalities occurred while the bicyclist was located in the vehicle travel lane, with 14% at the edge of the through vehicle travel lane and 10% in the shoulder area. The remainder of the fatalities occurred in roadway medians, right turn lanes, in on-street parking spaces or lanes, and in crosswalks. Sixty two percent of the fatalities involved bicyclists over the age of 20 years old. Of

¹ National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

those fatalities, 5% were between the ages of 21-24, 14% between 25-34 years old, 28% between 35-44 years old, and 15% were 45 years or older. From 1996 through 2001, 32 fatalities have occurred on Nevada's roadways. (See Table pg.# 50)

Pedestrian Injuries

In the U.S. in 1999, nearly 5,000 pedestrians died from traffic-related injuries and another 85,000 sustained nonfatal injuries. Children 15 and younger accounted for 12% of all pedestrian fatalities and 32% of all nonfatal pedestrian injuries. People 65 and older accounted for 22% of all pedestrian deaths and approximately 8% of all nonfatal pedestrian injuries. The pedestrian death rate for this age group is higher than any other age group. In the United States the pedestrian fatality rate is more than twice as high for men as for women. Hit and run incidents account for one out of five pedestrian deaths. In 1999, approximately one-third of pedestrians 14 and older who were killed by a MVC were intoxicated, with blood alcohol concentrations of .10% or more.¹ In Nevada, between 1996 and 2001, 332 pedestrians were killed on Nevada's roadways. (See Table pg. # 50)

Intimate Partner Violence

In the U.S., more women than men experience intimate partner violence. In a national survey, by the CDC, 25% of female participants reported being

¹ National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

raped or physically assaulted by an intimate partner at some time in their lives. In contrast, only 8% of male participants reported such an experience. Nearly two-thirds of women who reported being raped, physically assaulted, and/or stalked since age 18 were victimized by a current or former husband, cohabiting partner, boyfriend or date. Intimate partner violence is a major cause of violence-related injuries. One in three women injured during a physical assault or rape required medical care. In the U.S. women are also more likely than men to be murdered in the context of intimate partner violence. In 1998, 32% of all female homicide victims were murdered by an intimate partner. In contrast, 4% of male murder victims were killed by an intimate partner.¹

In Nevada between 1991 and 2000, according to the Total Index Crimes Report, collected by the Department of Motor Vehicles, 902 rapes and 6,034 assaults were reported and 167 murders occurred due to intimate partner violence.

The full extent of nonfatal and fatal intimate partner violence in the United States is not known. While the Federal Bureau of Investigation (FBI) provides data about deaths perpetrated by intimate partners, not all incidents are reported to police, and those that are reported may not be identified or recorded as intimate partner violence. Similarly, victims seeking medical care for intimate partner violence-related injuries may not disclose that their partners hurt them. Even if they do, the information may not be recorded in the medical record. To better document the scope of the problem of intimate partner violence and identify trends in incidence and prevalence, the quality of data collection at

¹ National Center for Injury Prevention and Control. *Injury Fact Book 2001-2002*. Atlanta, GA: Centers for Disease Control and Prevention; 2001.

national, state, and local levels must be improved. (No Tables or Graphs Included)

Definitions and Technical Notes

Definitions and Technical Notes

Age-Adjustment: is the application of age-specific rates in a population to a standardized age distribution (year 2000) in order to eliminate differences in observed rates that result from age differences in the population. Age-adjusted rates are useful for comparison purposes only, not to measure absolute magnitude.

Age Adjusted Death and Crude Death Rates: Both age-adjusted death rates and crude death rates are presented in graphs in this report. Including both rates is necessary because some injury mortalities are highly age-dependent compared to others. In this report, death rates are age-adjusted to the U.S. standard million population (relative age distribution of year 2000 enumerated U.S. population totaling 1,000,000). This method produces a rate that would be expected if the population of interest had the same age distribution as the standard population.

Age Distribution: The age distribution of Nevada's population varies from the nation as a whole by having a higher share of people in the age groups of 9 and under and between 25 and 74; while having a lower proportion of those 10 to 24 and those 75 and older. However, as an age group, the 75 and older population experienced the greatest change since 1990 with a statewide increase of 108%. This increase was focused in Clark County (130%), followed by all other counties, as a region, and Washoe County with an increase of 84% respectively.

County Comparisons: The population of the counties in Nevada varies widely, from a few thousand in the rural areas such as White Pine and Storey counties to over one million in Clark County. Because of these population differences and small denominators in the rural counties, caution should be used when interpreting the rates in this report and using them for comparisons purposes.

Death: A person who has sustained irreversible cessation of all functioning of the brain, including the brain stem, is considered dead (National Center for Health Statistics (NCHS)).

External Cause of Injury Coding (E-codes): External causes of injury and poisoning are a component of an internationally established classification system- the World Health Organization's International Classification of Disease Codes (ICD- 9th revision/ ICD- 10th revision). The diagnostic section of the classification system addresses injury diagnoses, such as fracture, laceration, burn, etc., while the e-code of the injury is used to group the circumstances of an injury or poisoning along two dimensions: intent and mechanism of injury. For example, the nature of an injury might be a cranial fracture, while the cause could be a fall, jump, motor vehicle collision, or sports injury.

Homicide - Injuries inflicted by another person with intent to injure or kill, by any means.

Hospital Discharge Data: **Caution should be used in interpreting this data.

This database under-reported injuries from 1995 to 1999. The Center for Health Data and Research, the Nevada State Health Division estimates that approximately 64.7% of E-code injuries were reported from 1995 to 1999.

ICD-Codes: Different ICD-codes were used when analyzing this report. ICD-9 codes were used from 1990-1998 while ICD-10 codes were used from 1999 to 2000. The weighted conversion variable was not taken into consideration when analyzing deaths in this report. Below is a table showing the errors between weighted and non-weighted deaths in different injury.

Injuries	Deaths from 1990 to 2000		
	Not Weighted	Weighted	Error (% difference)
Motor Vehicle Accident	3013	3013	0
Homicide	1747	1747	0
Suicide	3948	3948	0
Firearm	3887	3891	0.10
Unintentional Fire and Burn	194	207	6.28
Unintentional Fall	592	628	5.73
Unintentional Poisoning	815	854	4.57

Injury: Any intentional or unintentional damage to the body resulting from acute exposure to thermal, mechanical, electrical, or chemical energy or from the absence of such essentials as health or oxygen.

Intent of Injury: Most injuries are classified by “intent” as well as by mechanism. The three major intent categories are: assaultive injuries (the most severe outcome being homicide), self-inflicted injuries (the most severe outcome being suicide), and unintentional injuries. Assaultive and self-inflicted injuries

sometimes are combined in a single category - intentional injuries. There are two additional, smaller categories: legal intervention, which includes injuries caused by law enforcement in the line of duty, and undetermined. For fatal injuries, “undetermined” is a judgment of a medical examiner or coroner; in hospital discharge records, it is made by the health care provider. The reader should be aware of some difficulties inherent in classifying injuries according to intent. Because of the difficulty in determining “intent” and because public health interests and injury prevention strategies are more profitably focused on the mechanism of injury, this Data Surveillance emphasizes the mechanism of injury.

Legal Intervention: Injuries inflicted by the police or other law-enforcing agents, including military on duty, in the course of arresting or attempting to arrest lawbreakers, suppressing disturbances, maintaining order, and other legal actions. Excludes injuries caused by civil insurrections.

Mechanism of Injury: The mechanism of injury identifies the agent, instrument, product or activity that was involved in the series of events that led to the injury. This Data Surveillance Project highlights the mechanisms of injury available for reporting.

Notes from the Authors: This Data Surveillance Project is intended to be a summary of the problem of injury in Nevada, as represented in available data sources. The Nevada State Health Division encourages those whose programmatic activities require information on a level more detailed than we were

able to include here to write to Injury Prevention Coordinator, 505 E. King Street, Room #200 Carson City, Nevada 89701 with questions or comments.

Population Data: The Nevada population data used in this report are based on the database established by the Nevada State Demographer's Office and the Nevada Department of Taxation, as well as 1990 and 2000 Census data from the US Bureau of the Census.

Race/Ethnicity: The US Census identifies 4 races (White, Black, American Indian, Asian/Pacific Islander), and separately queries whether or not a person claims Hispanic ethnicity. In 2000, 66.8% of Nevada's population was White-Non Hispanic, Hispanic, Black- Non Hispanic, Asian- Non Hispanic, and Native American- Non Hispanic consisted of 20.4%, 6.8%, 5.0%, and 1.1% respectively.

Regional Comparisons: Approximately 86% of Nevada's population resides in the urban areas of Clark (Greater Las Vegas area) and Washoe (Greater Reno/Sparks area) Counties. In this Data Surveillance Project, data is frequently stratified into three regions within the state as follows: Clark County, Washoe County, and All Other Counties (all remaining 15 counties).

Suicide –An intentional self-inflicted injury that results in death.

Tables and Graphs

Tables

**10 Leading Causes of Death, Nevada
1998, All Races, Both Sexes¹**

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Congenital Anomalies 41	<u>Unintentional Injury and Adv. Effects</u> <u>19</u>	<u>Unintentional Injury and Adv. Effects</u> <u>8</u>	<u>Unintentional Injury and Adv. Effects</u> <u>13</u>	<u>Unintentional Injury and Adv. Effects</u> <u>102</u>	<u>Unintentional Injury and Adv. Effects</u> <u>82</u>	<u>Unintentional Injury and Adv. Effects</u> <u>142</u>	Heart Disease 287	Malignant Neoplasms 627	Heart Disease 3,205	Heart Disease 4,120
2	Respiratory Distress Syndrome 21	Congenital Anomalies 5	Pneumonia & Influenza 3	<u>Suicide</u> <u>7</u>	<u>Suicide</u> <u>47</u>	<u>Suicide</u> <u>59</u>	Malignant Neoplasms 106	Malignant Neoplasms 287	Heart Disease 508	Malignant Neoplasms 2,457	Malignant Neoplasms 3,523
3	SIDS 21	<u>Homicide & Legal Int.</u> <u>3</u>	Bronchitis Emphysema Asthma 2	<u>Homicide & Legal Int.</u> <u>4</u>	<u>Homicide & Legal Int.</u> <u>45</u>	<u>Homicide & Legal Int.</u> <u>46</u>	<u>Suicide</u> <u>93</u>	Liver Disease 89	Bronchitis Emphysema Asthma 107	Bronchitis Emphysema Asthma 797	Bronchitis Emphysema Asthma 947
4	Short Gestation 10	Malignant Neoplasms 3	Malignant Neoplasms 2	Malignant Neoplasms 4	Malignant Neoplasms 7	Malignant Neoplasms 29	Heart Disease 85	<u>Unintentional Injury and Adv. Effects</u> <u>85</u>	<u>Unintentional Injury and Adv. Effects</u> <u>60</u>	Cerebro-vascular 682	Cerebro-vascular 812
5	Remainder Respiratory 9	Heart Disease 2	Congenital Anomalies 1	Bronchitis Emphysema Asthma 1	Heart Disease 6	Heart Disease 26	Liver Disease 41	<u>Suicide</u> <u>80</u>	Cerebro-vascular 58	Pneumonia & Influenza 330	<u>Unintentional Injury and Adv. Effects</u> <u>665</u>
6	<u>Unintentional Injury and Adv. Effects</u> <u>8</u>	Perinatal Period 2	HIV 1	Congenital Anomalies 1	Congenital Anomalies 5	HIV 18	<u>Homicide & Legal Int.</u> <u>40</u>	Cerebro-vascular 49	Liver Disease 50	Septicemia 211	Pneumonia & Influenza 403
7	<u>Homicide & Legal Int.</u> <u>7</u>	Pneumonia & Influenza 2	Liver Disease 1	Diabetes 1	Bronchitis Emphysema Asthma 3	Liver Disease 13	HIV 26	Diabetes 25	<u>Suicide</u> <u>46</u>	Nephritis 183	<u>Suicide</u> <u>397</u>
8	Neonatal Hemorrhage 7	Benign Neoplasms 1			Cerebro-vascular 3	Diabetes 8	Cerebro-vascular 14	Bronchitis Emphysema Asthma 24	Diabetes 31	Diabetes 157	Septicemia 271
9	Pneumonia & Influenza 7	Bronchitis 1			Pneumonia & Influenza 2	Pneumonia & Influenza 6	Bronchitis Emphysema Asthma 13	HIV 24	Septicemia 31	<u>Unintentional Injury and Adv. Effects</u> <u>146</u>	Liver Disease 270
10	Perinatal Infections 6	HIV 1			Five Tied 1	Cerebro-vascular 4	Pneumonia & Influenza 13	Nephritis 16	Pneumonia & Influenza 28	Alzheimer Disease 113	Diabetes 232

Source from Web-based Injury Statistics Query and Reporting System (WISQARS) 1998.

MV Accident Deaths by Year, by Gender and by Race/Ethnicity, Nevada Residents, 1990-2000

Year	Gender		Race/Ethnicity						
	Male	Female	White	Black	Native	Asian	Hispanic	Other/ Unknown	Total
1990	215	86	234	17	8	6	36	0	301
1991	166	80	184	11	6	5	38	2	246
1992	145	54	152	15	7	6	19	0	199
1993	128	78	163	8	4	9	21	0	206
1994	187	73	198	24	7	3	28	1	260
1995	199	91	226	16	8	9	31	0	290
1996	206	99	233	18	5	5	43	0	305
1997	230	106	252	22	14	10	38	1	336
1998	205	110	236	18	5	9	46	0	315
1999	193	96	220	14	7	11	37	1	289
2000	176	90	180	24	10	8	44	0	266
Total	2050	963	2278	187	81	81	381	5	3013

Homicide Deaths by Year, by Gender and by Race/Ethnicity, Nevada Residents, 1990-2000

Year	Gender		Race/Ethnicity						
	Male	Female	White	Black	Native	Asian	Hispanic	Other/ Unknown	Total
1990	92	39	69	45	5	4	8	0	131
1991	119	41	95	32	6	4	22	1	160
1992	117	38	83	45	3	4	19	1	155
1993	114	32	76	38	5	4	22	1	146
1994	135	34	87	42	1	4	35	0	169
1995	119	46	88	43	3	1	28	2	165
1996	157	45	93	57	2	3	40	7	202
1997	122	44	88	29	2	3	44	0	166
1998	131	34	81	51	2	4	26	1	165
1999	113	47	77	35	4	10	33	1	160
2000	106	22	42	38	5	4	38	1	128
Total	1325	422	879	455	38	45	315	15	1747

Source from Vital Records, Nevada State Health Division (NSHD), 1990-2000

Suicide Deaths by Year, by Gender and by Race/Ethnicity, Nevada Residents, 1990-2000

Year	Gender		Race/Ethnicity						
	Male	Female	White	Black	Native	Asian	Hispanic	Other/ Unknown	Total
1990	240	54	247	13	11	2	21	0	294
1991	249	69	284	11	4	5	14	0	318
1992	269	60	293	18	3	4	11	0	329
1993	297	64	310	16	9	9	17	0	361
1994	271	78	297	13	9	4	25	1	349
1995	322	71	338	17	8	5	25	0	393
1996	274	54	278	14	7	6	21	2	328
1997	322	80	340	18	5	7	31	1	402
1998	304	85	344	14	3	8	20	0	389
1999	324	73	355	14	8	5	13	2	397
2000	320	68	330	14	2	7	34	1	388
Total	3192	756	3416	162	69	62	232	7	3948

Firearm Injury Deaths by Year, by Gender and by Race/Ethnicity, Nevada Residents, 1990-2000

Year	Gender		Race/Ethnicity						
	Male	Female	White	Black	Native	Asian	Hispanic	Other/ Unknown	Total
1990	242	42	218	32	12	2	20	0	284
1991	273	56	254	38	6	6	25	0	329
1992	284	58	266	46	3	4	23	0	342
1993	314	56	277	48	12	5	28	0	370
1994	308	60	256	50	7	6	48	1	368
1995	326	71	295	46	7	1	47	1	397
1996	302	51	239	53	6	7	43	5	353
1997	309	73	281	38	5	5	53	0	382
1998	310	54	263	54	4	5	38	0	364
1999	315	54	283	37	6	10	32	1	369
2000	287	42	233	35	3	7	50	1	329
Total	3270	617	2865	477	71	58	407	9	3887

Unintentional Fire/Burn Injury Deaths by Year, by Gender and by Race/Ethnicity, Nevada Residents, 1990-2000

Year	Gender		Race/Ethnicity						
	Male	Female	White	Black	Native	Asian	Hispanic	Other/ Unknown	Total
1990	13	6	13	3	0	0	2	1	19
1991	13	5	11	4	0	1	2	0	18
1992	20	6	21	3	0	0	2	0	26
1993	6	3	7	0	1	1	0	0	9
1994	16	7	15	6	1	1	0	0	23
1995	11	5	13	1	0	0	2	0	16
1996	8	6	12	0	0	0	2	0	14
1997	9	9	13	3	0	0	2	0	18
1998	11	6	13	2	0	0	2	0	17
1999	10	4	8	0	0	0	6	0	14
2000	9	11	14	5	0	0	1	0	20
Total	126	68	140	27	2	3	21	1	194

Drowning and Submersion Deaths by County of Residence, Nevada, 1994-2001

County of Residence	Children <=4								
	1994	1995	1996	1997	1998	1999	2000	2001	Total
Carson City	0	0	0	0	0	0	0	0	0
Churchill	0	0	0	0	0	0	0	0	0
Clark	11	5	8	5	10	8	6	3	56
Douglas	0	0	0	0	0	0	0	0	0
Elko	0		0	0	0	0	0	0	0
Esmeralda	0	0	0	0	0	0	0	0	0
Eureka	0	0	0	0	0	0	0	0	0
Humboldt	0	0	0	0	0	0	0	0	0
Lander	0	0	0	0	0	0	0	0	0
Lincoln	0	0	0	0	0	0	1	1	2
Lyon	0	1	0	0	0	0	0	0	1
Mineral	0	0	0	0	0	0	0	0	0
Nye	0	0	0	0	0	0	0	0	0
Pershing	0	0	0	0	0	0	0	0	0
Storey	1	1	1	0	0	1	2	0	6
Washoe	0	0	0	0	0	0	0	0	0
White Pine	0	0	0	0	0	0	0	0	0
NV Total	12	7	9	5	10	9	9	4	65
Out of State	0	1	1	0	1	1	1	1	6
Total	12	8	10	5	11	10	10	5	71

Source from Vital Records, Nevada State Health Division (NSHD), 1990-2000

**Drowning and Submersion Deaths by County of Residence, Nevada,
1994-2001**

County of Residence	People > = 5								
	1994	1995	1996	1997	1998	1999	2000	2001	Total
Carson City	0	0	0	0	0	0	0	0	0
Churchill	0	0	1	1	0	0	0	1	3
Clark	15	9	14	5	11	10	13	13	90
Douglas	0	0	1	0	0	0	1	0	2
Elko	0	1	0	0	5	1	0	2	9
Esmeralda	0	0	0	0	0	0	0	0	0
Eureka	0	0	0	0	0	0	0	0	0
Humboldt	0	1	0	1	1	0	1	0	4
Lander	0	0	0	0	0	1	0	1	2
Lincoln	0	0	0	0	0	0	0	0	0
Lyon	0	1	0	0	0	0	1	1	3
Mineral	0	0	0	0	0	0	0	0	0
Nye	0	0	0	0	0	1	0	0	1
Pershing	0	0	0	0	0	0	0	0	0
Storey	0	0	0	0	0	0	0	0	0
Washoe	5	3	2	4	1	4	2	1	22
White Pine	1	0	0	0	0	0	0	0	1
NV Total	21	15	18	11	18	17	18	19	137
Out of State	5	3	5	9	6	2	3	2	35
Total	26	18	23	20	24	19	21	21	172

**Unintentional Fall Injury Deaths by Year, by Gender and by Race/Ethnicity, Nevada Residents,
1990-2000**

Year	Gender		Race/Ethnicity						
	Male	Female	White	Black	Native	Asian	Hispanic	Other/ Unknown	Total
1990	20	15	30	1	0	2	2	0	35
1991	29	20	46	2	1	0	0	0	49
1992	26	17	42	1	0	0	0	0	43
1993	23	28	47	1	0	0	3	0	51
1994	27	19	39	3	2	0	2	0	46
1995	30	18	44	1	2	0	1	0	48
1996	36	19	50	1	1	1	2	0	55
1997	45	16	55	1	1	2	2	0	61
1998	34	24	50	3	1	1	3	0	58
1999	48	27	65	1	1	1	7	0	75
2000	44	27	60	2	3	4	2	0	71
Total	362	230	528	17	12	11	24	0	592

Source from Vital Records, Nevada State Health Division (NSHD), 1990-2001

**Unintentional Poisoning Deaths by Year, by Gender and by Race/Ethnicity, Nevada Residents,
1990-2000**

Year	Gender		Race/Ethnicity						
	Male	Female	White	Black	Native	Asian	Hispanic	Other/ Unknown	Total
1990	34	4	28	3	0	0	7	0	38
1991	22	7	23	3	1	0	2	0	29
1992	26	7	30	1	1	0	1	0	33
1993	38	8	38	1	1	1	5	0	46
1994	32	10	34	2	1	1	4	0	42
1995	45	16	49	4	4	0	4	0	61
1996	53	8	49	8	0	0	4	0	61
1997	63	25	67	9	1	1	10	0	88
1998	66	25	71	14	1	0	5	0	91
1999	93	50	118	11	2	0	12	0	143
2000	139	44	160	11	1	0	11	0	183
Total	611	204	667	67	13	3	65	0	815

See ICD Codes in Definitions and Technical Notes
Source from Vital Records, Nevada State Health Division (NSHD), 1990-2000

**Washoe Poison Center Jan - Oct 2001
Case Reports in Nevada**

Category	<= 5 Years	6-19 Years	> = 20 Years	Unknown	Total	%
Analgesics	184	98	178	12	472	10.84
Cosmetics/personal care products	283	26	61	3	373	8.56
Cleaning substances (household)	212	29	106	0	347	7.97
Plants	155	18	39	0	212	4.87
Antidepressants	21	34	135	1	191	4.38
Bites and envenomations	21	45	103	1	170	3.90
Sedative/hypnotics/antipsychotics	14	14	130	4	162	3.72
Foreign bodies/toys/miscellaneous	129	22	8	0	159	3.65
Topical preparations	128	9	16	0	153	3.51
Cold and cough preparations	88	36	15	1	140	3.21
Alcohols	20	20	85	4	129	2.96
Antihistamines	57	22	40	2	121	2.78
Hydrocarbons	50	15	46	1	112	2.57
Cardiovascular drugs	38	4	70	0	112	2.57
Vitamins	88	8	14	0	110	2.53
Pesticides	51	16	33	2	102	2.34
Hormones and hormone antagonists	48	8	39	1	96	2.20
Antimicrobials	64	5	22	1	92	2.11
Gastrointestinal preparations	74	4	10	0	88	2.02
Chemicals	25	18	36	1	80	1.84
Food products/food poisoning	25	12	42	0	79	1.81
Dietary supplements/herbals/homeopathn	41	8	16	0	65	1.49
Arts/crafts/office supplies	45	18	1	0	64	1.47
Electrolytes and minerals	55	1	5	0	61	1.40
Anticonvulsants	8	10	40	0	58	1.33
Stimulants and street drugs	7	28	20	0	55	1.26
Muscle relaxants	5	6	29	1	41	0.94
Fumes/gases/vapors	3	5	27	0	35	0.80
Industrial cleaners	11	7	15	0	33	0.76
Miscellaneous drugs	14	4	14	0	32	0.73
Adhesives/glue	13	9	9	0	31	0.71
Asthma therapies	20	4	7	0	31	0.71
Eye/ear/nose/throat preparations	21	1	8	0	30	0.69
Fertilizers	20	3	5	0	28	0.64
Automotive/aircraft/boat products	10	4	11	2	27	0.62
Heavy metals	6	4	15	1	26	0.60
Paints and stripping agents	16	3	6	1	26	0.60
Deodorizers	15	4	3	0	22	0.51
Tobacco products	20	0	0	0	20	0.46
Anesthetics	15	2	2	0	19	0.44
Building and construction products	10	0	7	0	17	0.39
Unknown Drug	3	3	11	0	17	0.39
Other/unknown nondrug substances	9	3	4	0	16	0.37
Diuretics	7	3	5	0	15	0.34
Essential oils	10	0	4	0	14	0.32
Swimming pool/aquarium	8	2	2	0	12	0.28
Fire extinguishers	1	2	7	0	10	0.23
Mushrooms	6	4	0	0	10	0.23
Batteries	2	1	3	0	6	0.14
Polishes and waxes	4	1	1	0	6	0.14
Anticholinergic drugs	0	0	5	1	6	0.14
Serums, toxoids, vaccines	0	2	3	0	5	0.11
Dyes	3	0	1	0	4	0.09
Veterinary drugs	3	0	1	0	4	0.09
Anticoagulants	0	0	3	0	3	0.07
Lacrimator	0	1	1	0	2	0.05
Antineoplastics	0	0	2	0	2	0.05
Photographic products	1	0	0	0	1	0.02
Sporting equipment	1	0	0	0	1	0.02
Narcotic antagonists	0	0	1	0	1	0.02
Total	2188	606	1522	40	4356	100

Pedestrian and Pedal Cyclist Mortality by Age Groups, Nevada Residents, 1996-2001

Type of Accident and Year		Age Groups												
		<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Unknown	Total
Pedestrian	1996	0	3	3	1	6	16	10	8	3	7	3	2	62
	1997	1	6	5	8	8	9	12	5	6	5	1	1	67
	1998	0	0	0	5	4	8	4	11	6	3	1	0	42
	1999	0	1	3	3	5	22	11	12	5	6	2	0	70
	2000	1	1	4	9	3	6	8	3	2	5	1	0	43
	2001	0	1	2	3	5	8	11	7	3	3	5	0	48
	1996-2001 Total	2	12	17	29	31	69	56	46	25	29	13	3	332
Pedal cyclist	1996	0	0	1	2	1	0	0	1	1	0	0	0	6
	1997	0	0	1	2	1	0	0	0	1	0	0	0	5
	1998	0	0	1	2	1	0	0	0	0	0	0	0	4
	1999	0	0	0	1	2	5	0	0	1	0	0	0	9
	2000	0	0	2	0	0	0	1	0	0	1	0	0	4
	2001	0	0	1	1	0	0	1	0	0	1	0	0	4
	1996-2001 Total	0	0	6	8	5	5	2	1	3	2	0	0	32

Note: Data prior to 1999 may not be directly comparable with 1999-2001 data, because of the change in 1999 from the ICD-9 cause of death classification system to the ICD-10 classification system.

Behavioral Risk Factor Surveillance Survey

% Do not have a smoke detector in their home, BRFSS in Nevada

Nevada	1999	1997	1995
Gender	%	%	%
Male	9.1	2	5.5
Female	6.6	3	4.6

Age	%	%	%
18-24	12.2	2.3	6.1
25-34	8.9	1.1	2.7
35-44	5.5	1.4	3.5
45-54	0.6	2.6	5.4
55-65	3.4	3.9	7.4
65+	12	5.2	8.1

Race	%	%	%
White	4.5	2.9	4.9
Black	26	0	1.2
Hispanic	8.6	2.6	5.3
Other	14.1	0.3	12.6

Income	%	%	%
Less than \$15,000	5.1	5.4	11.4
\$15,000-24,999	14.5	6.5	6.9
\$25,000-34,999	14	1.6	4.6
\$35,000-49,999	9	2.3	2.9
\$50,000+	1.9	1	3.5

Education	%	%	%
Less than H.S.	29.7	7.9	12
H.S. or G.E.D.	5.6	2.9	5.5
Some post-H.S.	5.2	2.1	3.3
College graduate	3.2	0.8	4.3

% Do not wear seatbelts when driving or riding in a car in Nevada

Nevada	1997	1995
Gender	%	%
Male	15.6	18
Female	7.3	11.5

Age	%	%
18-24	17.3	17.5
25-34	10.7	16.3
35-44	11.5	16.2
45-54	7.2	11.1
55-65	9.6	11.2
65+	14.8	15.5

Race	%	%
White	11.1	14.8
Black	1.8	8.2
Hispanic	15	20.8
Other	12.2	11.8

Income	%	%
Less than \$15,000	6.4	25
\$15,000-24,999	23.4	18
\$25,000-34,999	9.8	19.3
\$35,000-49,999	8.3	11.1
\$50,000+	12.7	11.2

Education	%	%
Less than H.S.	25.9	25.2
H.S. or G.E.D.	11.3	19.7
Some post-H.S.	9.5	14
College graduate	10	5.5

2001 Nevada Youth Risk Behavior Survey Nevada Data (in percentages)	Middle School	High School	National (only HS data available)
Rarely or never wear a seat belt when riding in a car driven by someone else	13.6%	17.5%	14.1%
Rarely or never wear a helmet when riding a bicycle	62.2%	N/A	84.7%
Rarely or never wear a helmet when rollerblading or skateboarding	53.2%	N/A	N/A
Usual method of getting to/from school is walking or riding a bicycle	25.3%	N/A	N/A
In past 30 days, rode in a car or other vehicle driven by someone who had been drinking alcohol	19.7%	29.9%	30.7%
In past 30 days, drank and drove	6.4%	13.2%	13.3%
Only sometimes, rarely or never feel safe and secure in their neighborhood	22.1%	17.0%	N/A
Only sometimes, rarely or never feel safe and secure at school	29.5%	30.5%	N/A
In past 30 days, did not go to school on ≥ 1 days because they felt unsafe at school or on the way to or from school	12.8%	16.9%	6.6%
In past 30 days, were offended, threatened, frightened, or attacked ≥ 1 times because of their racial or ethnic background	23.6%	19.3%	N/A
In past 30 days, were offended, threatened, frightened, or attacked one or more times because of their gender	15.4%	14.9%	N/A
Ever belonged to a street gang	10.3%	14.3%	N/A
Believe there is gang activity in their school	25.5%	40.4%	N/A
In the last 12 months, were in ≥ 1 physical fights	41.3%	35.6%	33.2%
In past 12 months, were in ≥ 1 physical fights on school property	22.7%	13.0%	12.5%
In past 30 days, carried a weapon ≥ 1 days	13.3%	15.9%	17.4%
In past 30 days, carried a weapon ≥ 1 times on school property	5.4%	6.9%	6.4%
In past 12 months, someone threatened or injured them with a weapon on school property	9.0%	8.8%	8.9%
In past 12 months, were ever hit, slapped or physically hurt on purpose by their boyfriend or girlfriend	9.3%	12.1%	9.5%
Ever been forced to have sexual intercourse against their will	N/A	9.2%	7.7%
In past 12 months, seriously considered attempting suicide	16.4%	19.6%	19.0%
In past 12 months, made a specific plan about how they would attempt suicide	11.9%	16.4%	14.8%
In past 12 months, actually attempted suicide ≥ 1 times	11.9%	10.7%	8.8%
Of those who attempted suicide in past 12 months, attempts resulted in injury, poisoning or overdose that required treatment by a doctor or nurse	N/A	3.8%	2.6%

Persons Killed, by Highest Blood Alcohol Concentration in Crashes in Nevada, 1994-2000

Nevada	Highest Blood Alcohol Concentration in Crash						Total Killed in Alcohol-Related Crashes		Total Killed	
	BAC = 0.00		BAC = 0.01-0.09		BAC = 0.10+					
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1994	146	50	28	10	119	41	148	50	294	100
1995	159	51	27	9	127	41	154	49	313	100
1996	174	50	44	13	130	37	174	50	348	100
1997	187	54	43	12	117	34	160	46	347	100
1998	184	51	49	14	128	35	177	49	361	100
1999	194	55	52	15	105	30	156	45	350	100
2000	178	55	32	10	112	35	145	45	323	100

Drivers Involved in Fatal Crashes by Blood Alcohol Concentration of the Driver in Nevada, 1994-2000

Nevada	Blood Alcohol Concentration of the Driver						Any Alcohol (BAC=0.01+)		Total Drivers Involved in Fatal Crashes	
	BAC = 0.00		BAC = 0.01-0.09		BAC = 0.10+					
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1994	246	66	32	9	92	25	124	34	370	100
1995	266	67	32	8	97	24	129	33	395	100
1996	296	67	43	10	104	23	147	33	443	100
1997	347	72	48	10	89	18	138	28	485	100
1998	332	70	55	12	90	19	146	30	478	100
1999	332	73	44	9	82	18	126	27	458	100
2000	276	69	34	8	90	22	123	31	399	100

MV Crash Injury Hospital Inpatient Discharge Table

Detail Information									
Year of Discharge	Total Number of Discharges	Total Charges (U.S. dollars)	Average (Mean) Total Charge (U.S. dollars)	Lowest Total Charge (U.S. dollars)	Highest Total Charge (U.S. dollars)	Total of Length of Stay (days)	Average (Mean) Length of Stay (days)	Minimum Length of Stay (days)	Maximum Length of Stay (days)
1995	1,873	\$42,580,233	\$22,733.71	\$55	\$547,813	11,218	5.99	1	157
1996	1,797	\$37,602,900	\$20,925.38	\$118	\$313,417	9,449	5.26	1	117
1997	1,550	\$34,184,671	\$22,054.63	\$336	\$382,063	8,319	5.37	1	103
1998	2,168	\$53,518,352	\$24,685.59	\$763	\$316,172	11,579	5.34	1	98
1999	1,072	\$33,290,253	\$31,054.34	\$1,168	\$615,082	6,485	6.05	1	152

Homicide/Assault Injury Hospital Discharge Table

Detail Information									
Year of Discharge	Total Number of Discharges	Total Charges (U.S. dollars)	Average (Mean) Total Charge (U.S. dollars)	Lowest Total Charge (U.S. dollars)	Highest Total Charge (U.S. dollars)	Total of Length of Stay (days)	Average (Mean) Length of Stay (days)	Minimum Length of Stay (days)	Maximum Length of Stay (days)
1995	651	\$11,057,384	\$16,985.23	\$813	\$164,319	3,341	5.13	1	128
1996	688	\$10,863,672	\$15,790.22	\$644	\$145,575	3,002	4.36	1	59
1997	517	\$8,907,387	\$17,228.99	\$693	\$146,940	2,309	4.47	1	82
1998	637	\$12,309,887	\$19,324.78	\$808	\$333,638	3,355	5.27	1	112
1999	346	\$6,823,336	\$19,720.62	\$1,508	\$312,120	1,514	4.38	1	49

Suicide/Self-inflicted Injury Hospital Inpatient Discharge Table

Detail Information									
Year of Discharge	Total Number of Discharges	Total Charges (U.S. dollars)	Average (Mean) Total Charge (U.S. dollars)	Lowest Total Charge (U.S. dollars)	Highest Total Charge (U.S. dollars)	Total of Length of Stay (days)	Average (Mean) Length of Stay (days)	Minimum Length of Stay (days)	Maximum Length of Stay (days)
1994	521	\$4,008,015	\$7,692.93	\$565	\$107,736	6,043	4.47	1	72
1995	644	\$6,469,822	\$10,046.31	\$392	\$151,182	11,218	5.99	1	157
1996	626	\$6,572,604	\$10,499.37	\$575	\$670,258	9,449	5.26	1	117
1997	541	\$6,406,679	\$11,842.29	\$889	\$210,448	8,319	5.37	1	103
1998	741	\$8,590,011	\$11,592.46	\$566	\$161,057	11,579	5.34	1	98
1999	583	\$7,033,708	\$12,064.68	\$732	\$229,073	6,485	6.05	1	152

** See Hospital Discharge Data in Definitions and Technical Notes
Source HDD, 1994-1999

Firearm Related Injury Hospital Inpatient Discharge Table

Detail Information									
Year of Discharge	Total Number of Discharges	Total Charges (U.S. dollars)	Average (Mean) Total Charge (U.S. dollars)	Lowest Total Charge (U.S. dollars)	Highest Total Charge (U.S. dollars)	Total of Length of Stay (days)	Average (Mean) Length of Stay (days)	Minimum Length of Stay (days)	Maximum Length of Stay (days)
1995	267	\$6,039,135	\$22,618.48	\$13,726	\$177,778	1,452	5.44	1	144
1996	277	\$6,389,612	\$23,067.19	\$13,729	\$670,258	1,415	5.11	1	59
1997	203	\$4,973,591	\$24,500.45	\$15,991	\$210,448	1,141	5.62	1	74
1998	187	\$5,521,032	\$29,524.24	\$17,895	\$200,299	1,378	7.37	1	112
1999	92	\$2,690,253	\$29,241.88	\$15,198	\$219,838	506	5.5	1	50

Unintentional Fire and Burn Injury Hospital Inpatient Discharge Table

Detail Information									
Year of Discharge	Total Number of Discharges	Total Charges (U.S. dollars)	Average (Mean) Total Charge (U.S. dollars)	Lowest Total Charge (U.S. dollars)	Highest Total Charge (U.S. dollars)	Total of Length of Stay (days)	Average (Mean) Length of Stay (days)	Minimum Length of Stay (days)	Maximum Length of Stay (days)
1995	141	\$2,555,192	\$18,121.93	\$9,092	\$140,102	1,344	9.53	1	72
1996	140	\$3,022,091	\$21,586.36	\$9,482	\$181,857	1,255	8.96	1	56
1997	104	\$1,623,470	\$15,610.29	\$8,353	\$136,732	701	6.74	1	47
1998	169	\$3,472,591	\$20,547.88	\$8,990	\$194,880	1,447	8.56	1	97
1999	67	\$1,186,594	\$17,710.36	\$10,907	\$92,525	466	6.96	1	31

Unintentional Poisoning Hospital Inpatient Discharge Table

Detail Information									
Year of Discharge	Total Number of Discharges	Total Charges (U.S. dollars)	Average (Mean) Total Charge (U.S. dollars)	Lowest Total Charge (U.S. dollars)	Highest Total Charge (U.S. dollars)	Total of Length of Stay (days)	Average (Mean) Length of Stay (days)	Minimum Length of Stay (days)	Maximum Length of Stay (days)
1995	297	\$2,205,802	\$7,426.94	\$0	\$66,492	834	2.81	1	38
1996	375	\$2,877,421	\$7,673.12	\$513	\$125,426	920	2.45	1	40
1997	355	\$3,554,808	\$10,013.54	\$344	\$113,761	1,100	3.1	1	75
1998	472	\$4,608,261	\$9,763.26	\$139	\$133,249	1,276	2.7	1	36
1999	344	\$4,420,573	\$12,850.50	\$353	\$140,863	1,188	3.45	1	91

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** See Hospital Discharge Data in Definitions and Technical Notes
Source HDD, 1995-1999

Unintentional Fall Injury Hospital Inpatient Discharge Table

Detail Information									
Year of Discharge	Total Number of Discharges	Total Charges (U.S. dollars)	Average (Mean) Total Charge (U.S. dollars)	Lowest Total Charge (U.S. dollars)	Highest Total Charge (U.S. dollars)	Total of Length of Stay (days)	Average (Mean) Length of Stay (days)	Minimum Length of Stay (days)	Maximum Length of Stay (days)
1995	2,231	\$35,825,156	\$16,057.89	\$359	\$232,416	11,704	5.25	1	117
1996	2,410	\$39,310,391	\$16,311.37	\$464	\$282,753	11,989	4.97	1	103
1997	2,251	\$40,339,348	\$17,920.63	\$415	\$278,779	10,742	4.77	1	56
1998	3,286	\$61,392,798	\$18,683.14	\$453	\$741,566	16,287	4.96	1	132
1999	2,513	\$49,860,507	\$19,841.03	\$610	\$541,953	12,826	5.1	1	101

Traumatic Brain Injury Hospital Inpatient Discharge Table

Detail Information									
Year of Discharge	Total Number of Discharges	Total Charges (U.S. dollars)	Average (Mean) Total Charge (U.S. dollars)	Lowest Total Charge (U.S. dollars)	Highest Total Charge (U.S. dollars)	Total of Length of Stay (days)	Average (Mean) Length of Stay (days)	Minimum Length of Stay (days)	Maximum Length of Stay (days)
1995	1765	\$48,780,369	\$27,653.27	\$374	\$464,263	13574	7.69	1	261
1996	1740	\$46,595,462	\$26,779.00	\$460	\$458,832	12362	7.1	1	167
1997	1377	\$39,989,886	\$29,041.31	\$628	\$382,063	10027	7.28	1	181
1998	1809	\$52,047,424	\$28,771.38	\$260	\$453,850	12295	6.8	1	135
1999	1775	\$60,037,162	\$33,823.75	\$328	\$541,876	12244	6.9	1	153

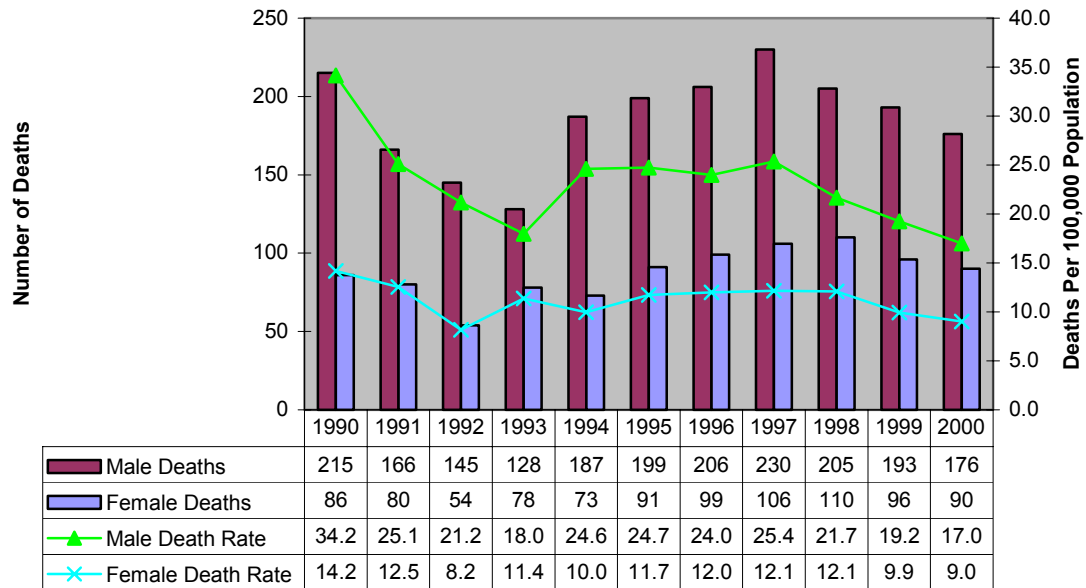
Traumatic Spinal Cord Injury Hospital Inpatient Discharge Table

Detail Information									
Year of Discharge	Total Number of Discharges	Total Charges (U.S. dollars)	Average (Mean) Total Charge (U.S. dollars)	Lowest Total Charge (U.S. dollars)	Highest Total Charge (U.S. dollars)	Total of Length of Stay (days)	Average (Mean) Length of Stay (days)	Minimum Length of Stay (days)	Maximum Length of Stay (days)
1995	116	\$9,345,154	\$80,561.67	\$2,420	\$547,813	2178	18.78	1	103
1996	109	\$6,472,113	\$59,377.18	\$1,958	\$316,559	1605	14.72	1	133
1997	85	\$5,248,950	\$61,752.35	\$3,364	\$278,779	1072	12.61	1	75
1998	102	\$8,018,745	\$78,615.15	\$4,204	\$741,566	1624	15.92	1	132
1999	111	\$8,477,103	\$76,370.30	\$4,093	\$429,937	1392	12.54	1	62

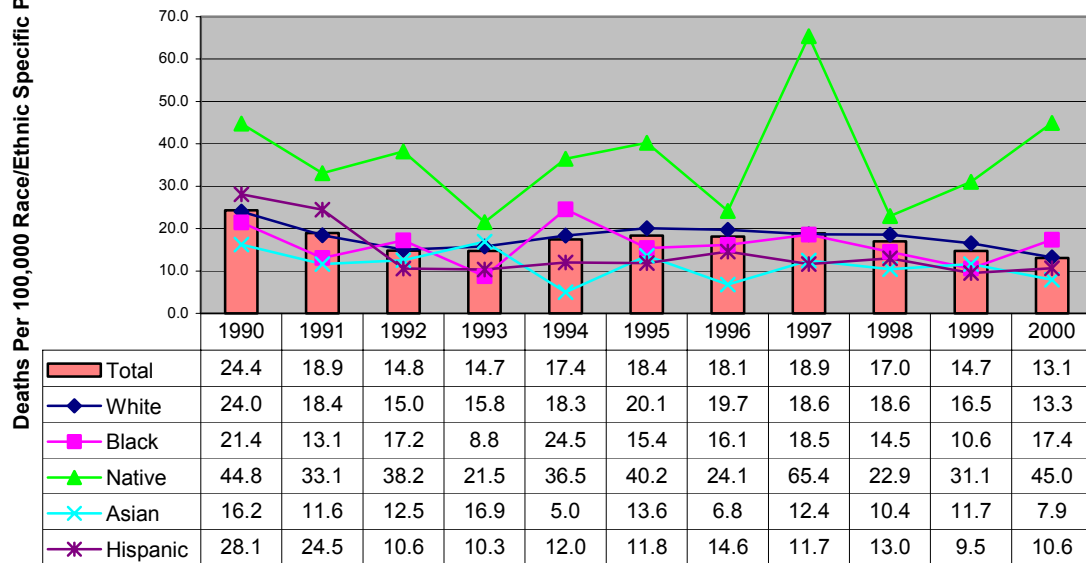
** See Hospital Discharge Data in Definitions and Technical Notes
Source HDD, 1995-1999

Graphs

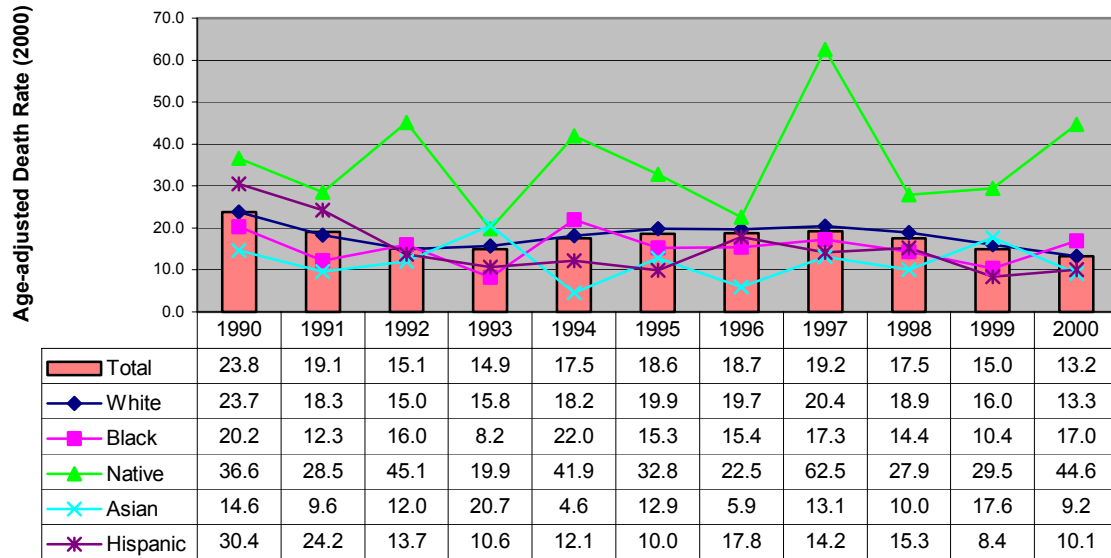
Motor Vehicle Accident Deaths by Gender, Nevada Residents, 1990-2000



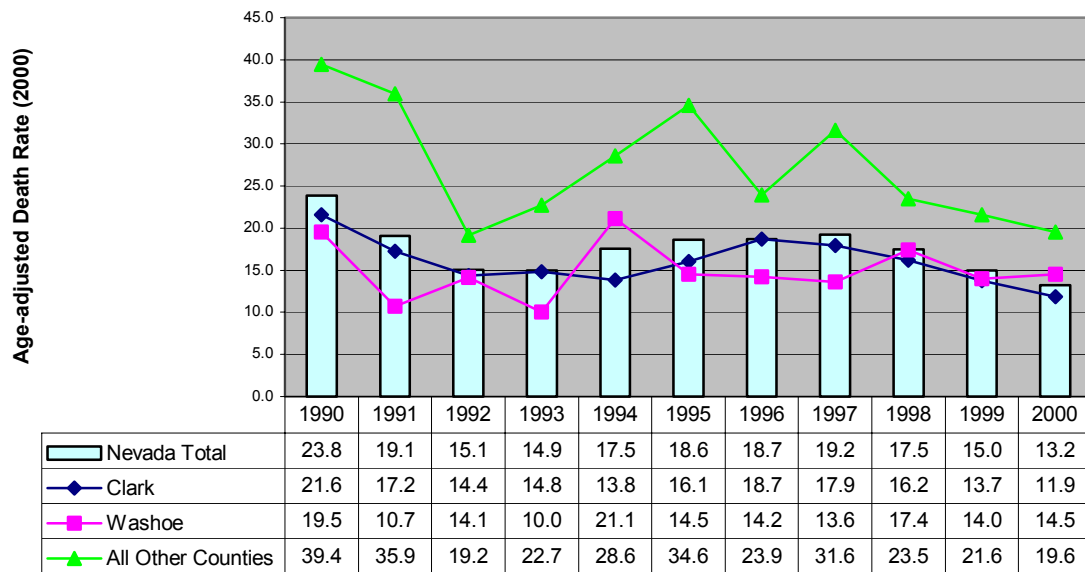
Motor Vehicle Accident Mortality Rates by Race/Ethnicity, Nevada Residents, 1990-2000



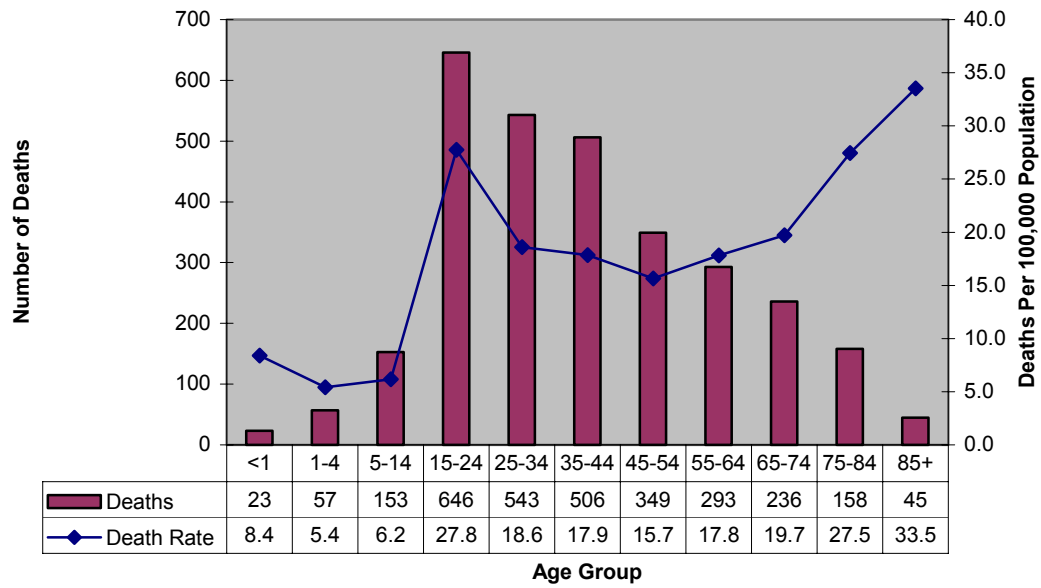
Motor Vehicle Accident Age-Adjusted Death Rates (2000), Nevada, 1990-2000



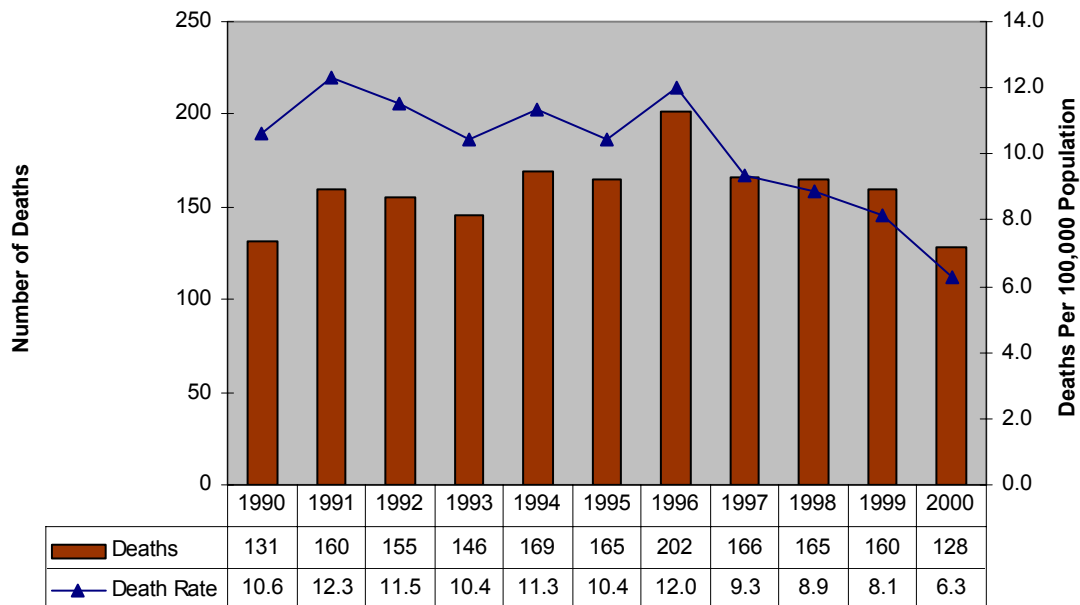
Motor Vehicle Accident Age-Adjusted Death Rates (2000), Nevada, 1990-2000



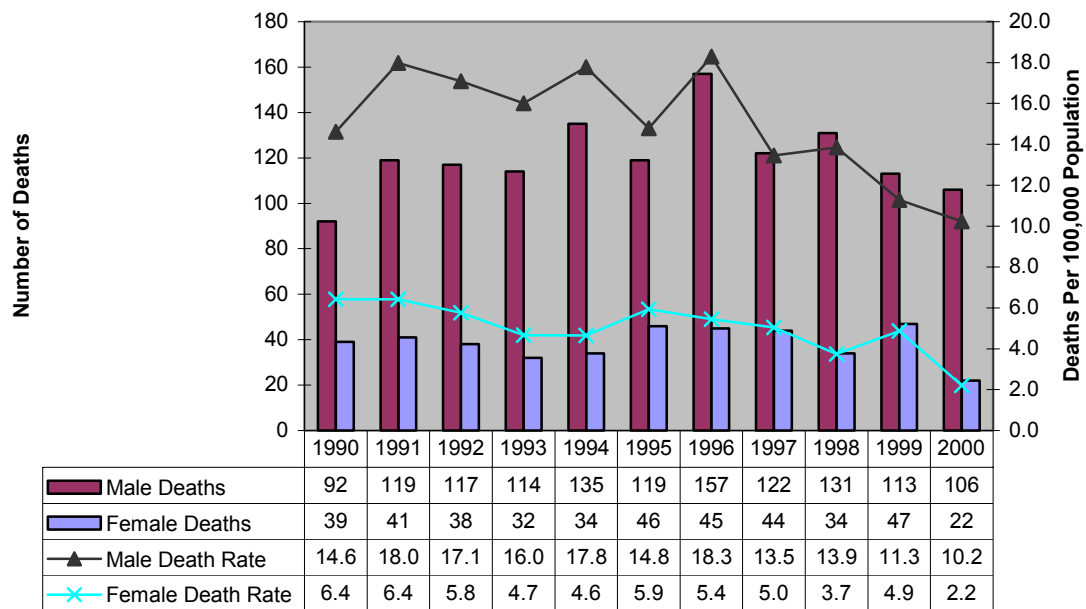
**Motor Vehicle Accident Deaths by Age Group,
Nevada Residents, 1990-2000**



Homicide Deaths by Year, Nevada Residents, 1990-2000

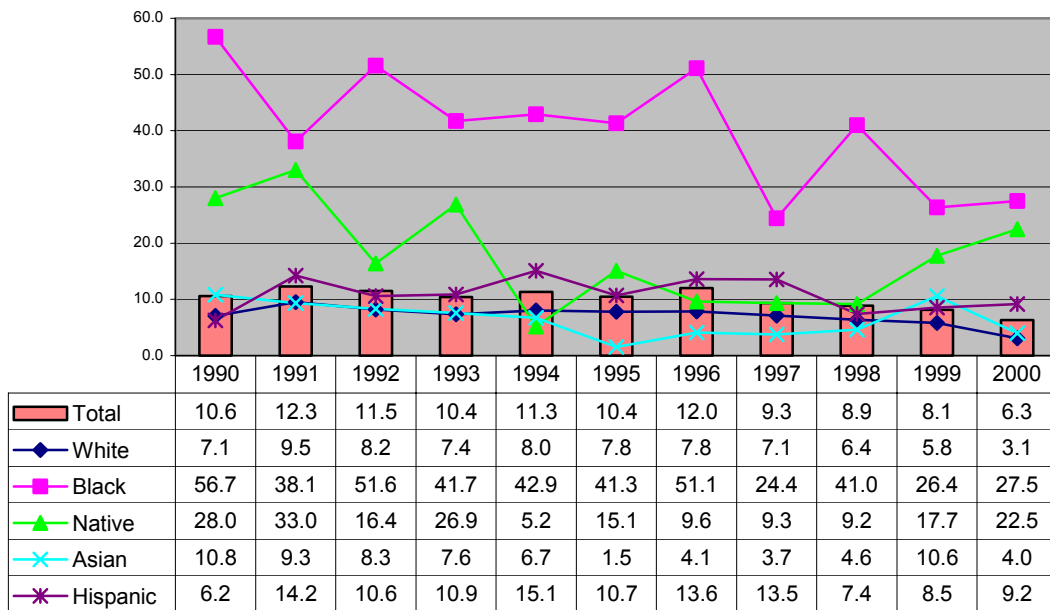


Homicide Deaths by Gender, Nevada Residents, 1990-2000

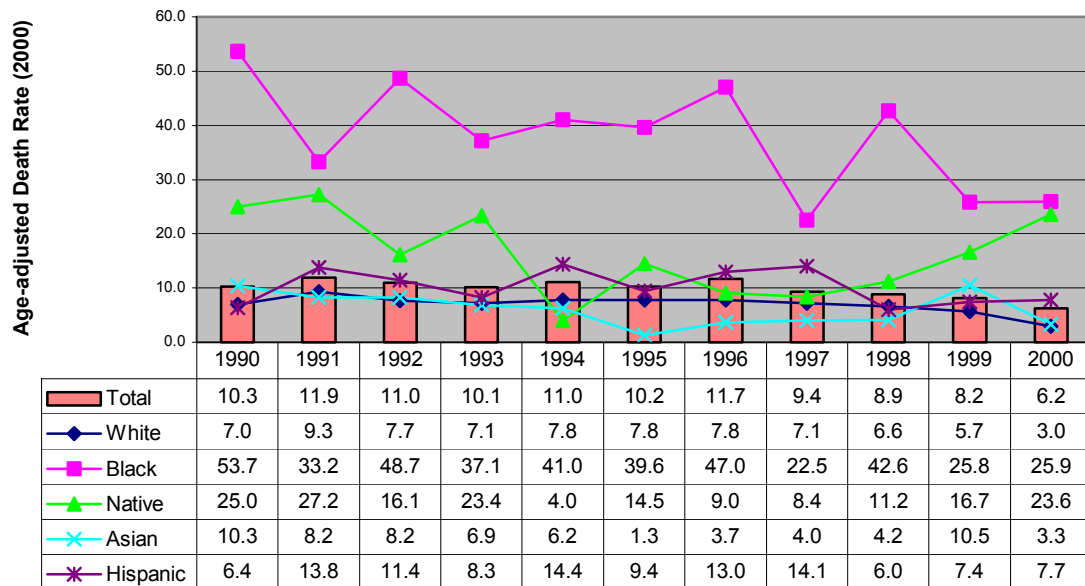


Deaths Per 100,000 Race/Ethnic Specific Population

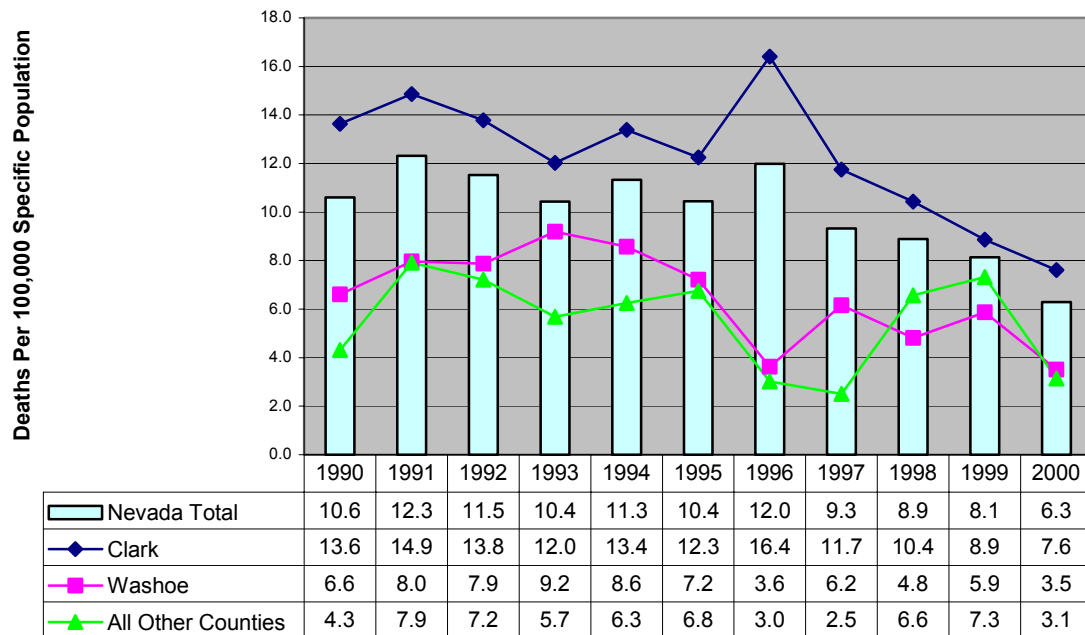
Homicide Mortality Rates By Race/Ethnicity, Nevada Residents, 1990-2000



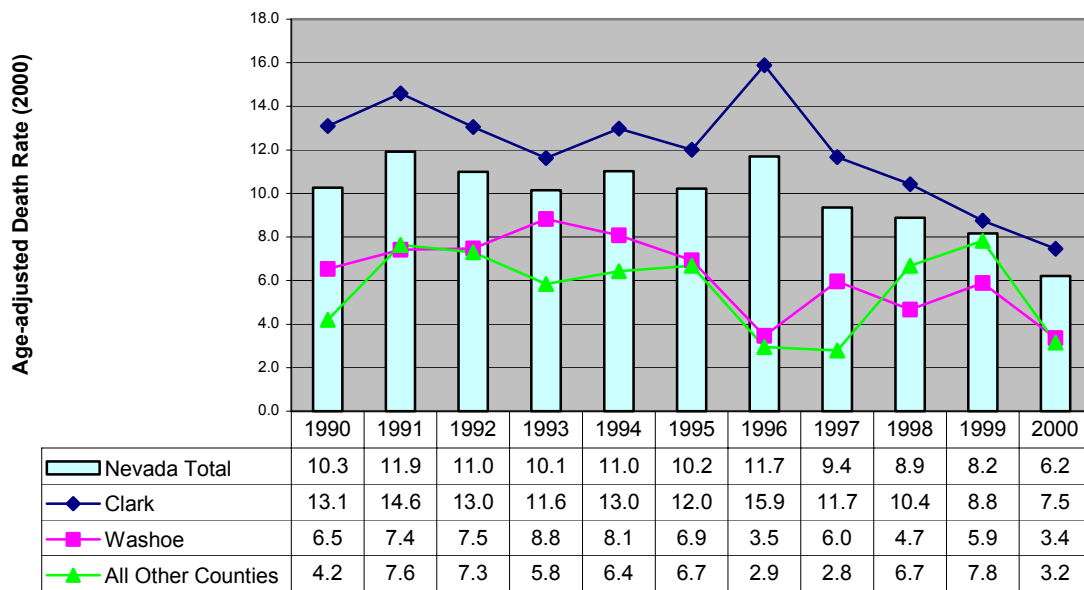
Homicide Age-Adjusted Death Rates (2000), Nevada, 1990-2000



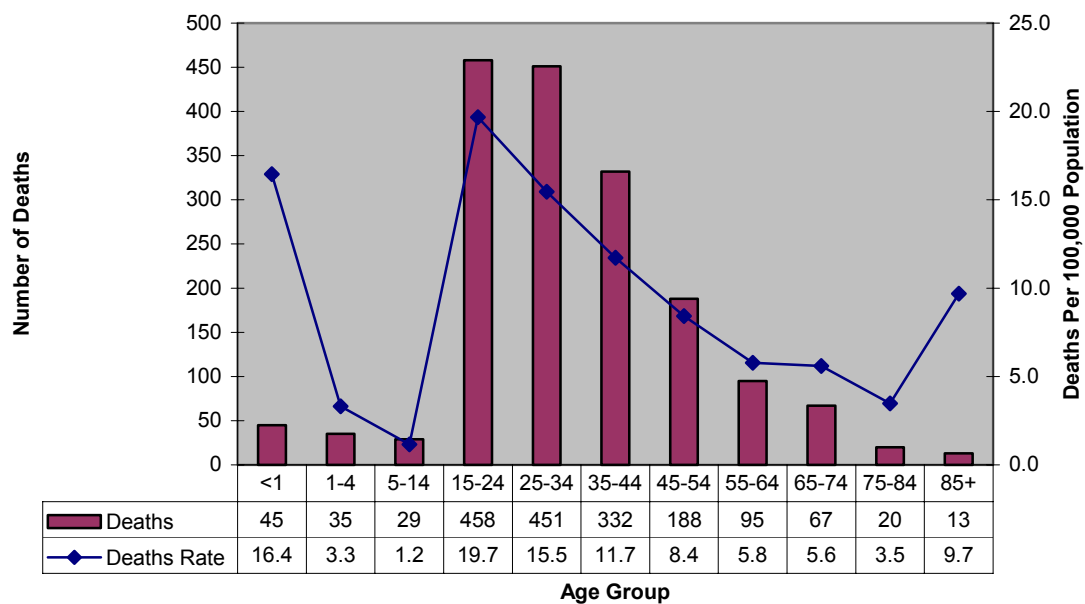
Homicide Mortality Rates By County of Residence, Nevada, 1990-2000



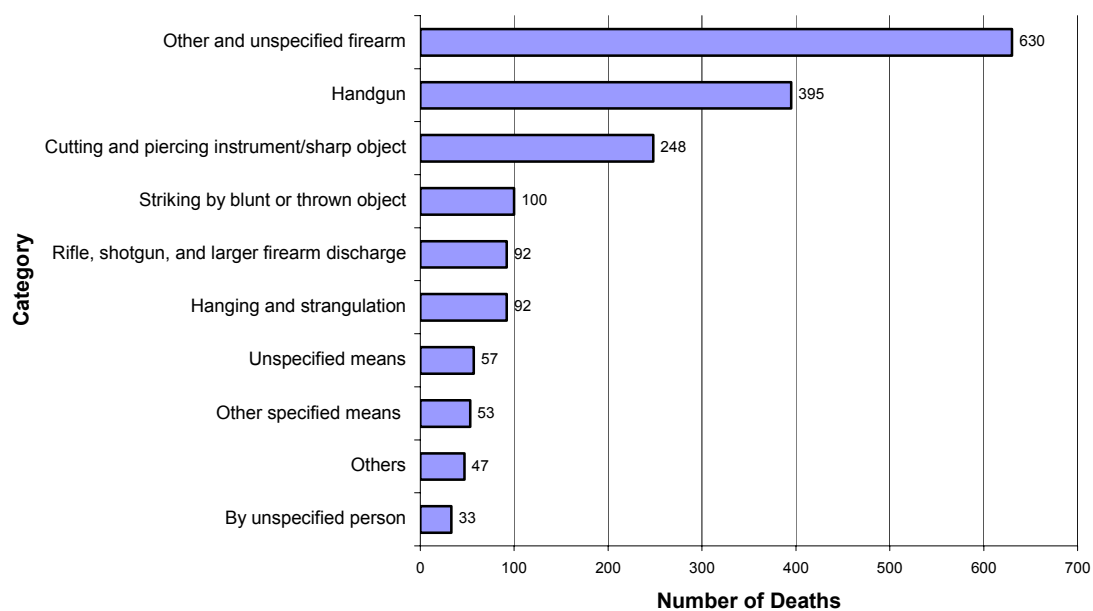
Homicide Age-Adjusted Death Rates (2000), Nevada, 1990-2000



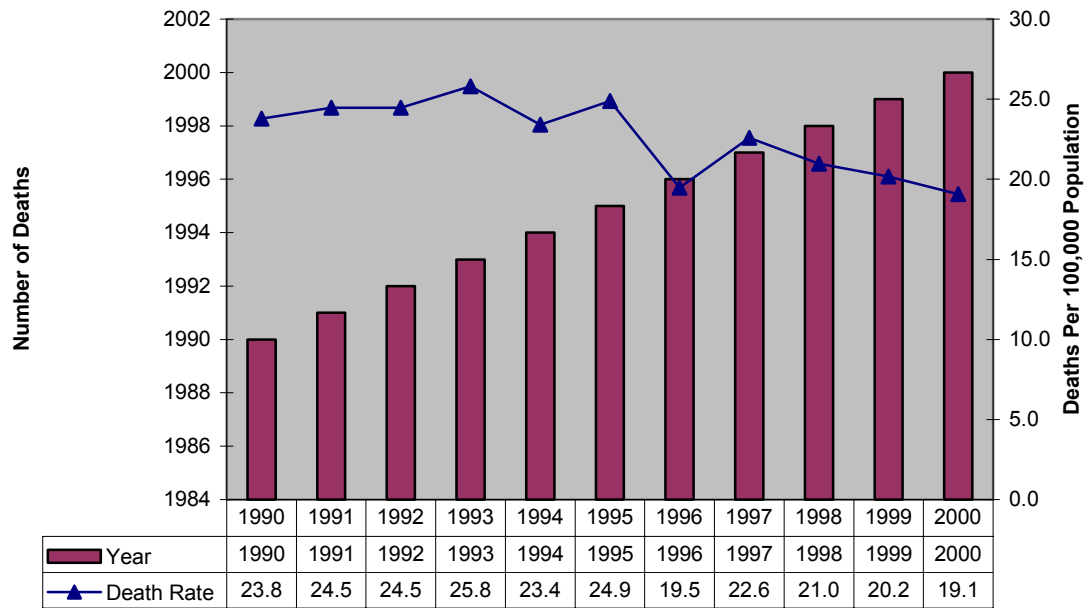
Homicide Deaths By Age, Nevada Residents, 1990-2000



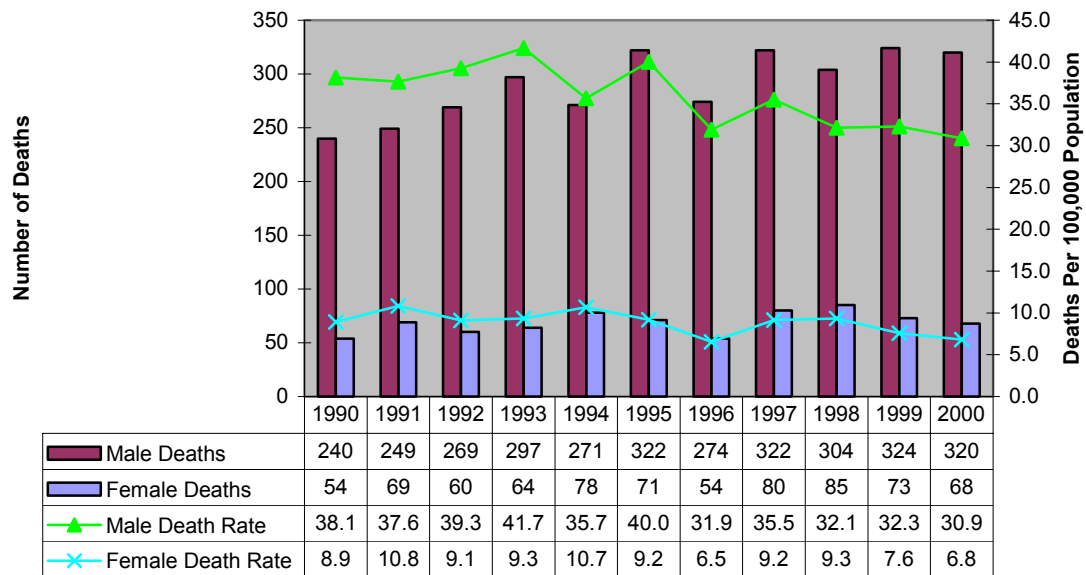
Homicide Deaths by Category, Nevada Residents, 1990-2000



Suicide Deaths By Year, Nevada Residents, 1990-2000

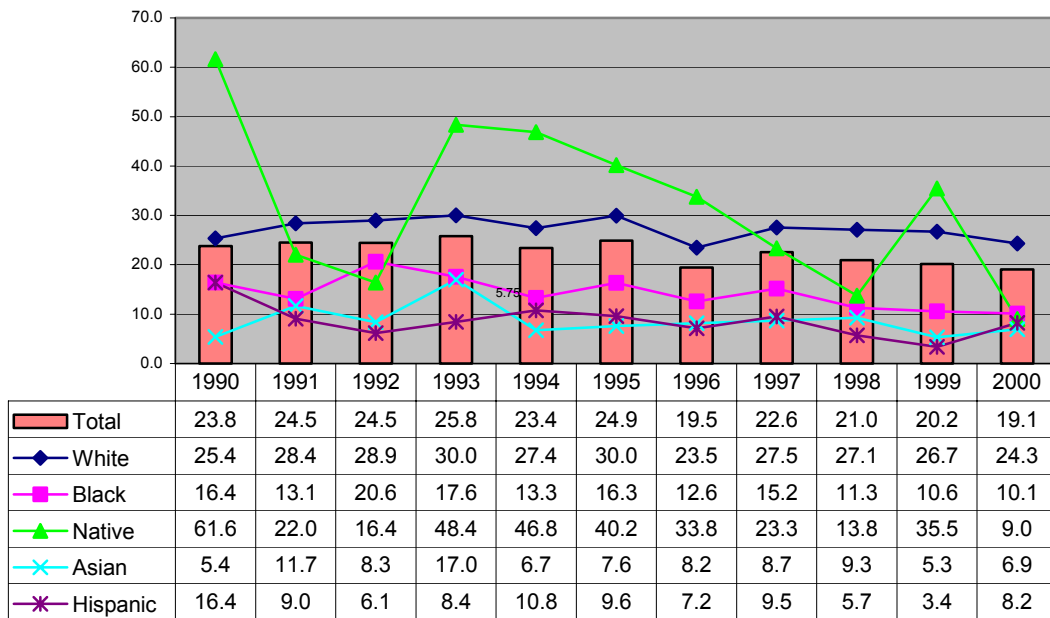


Suicide Deaths By Gender, Nevada Residents, 1990-2000

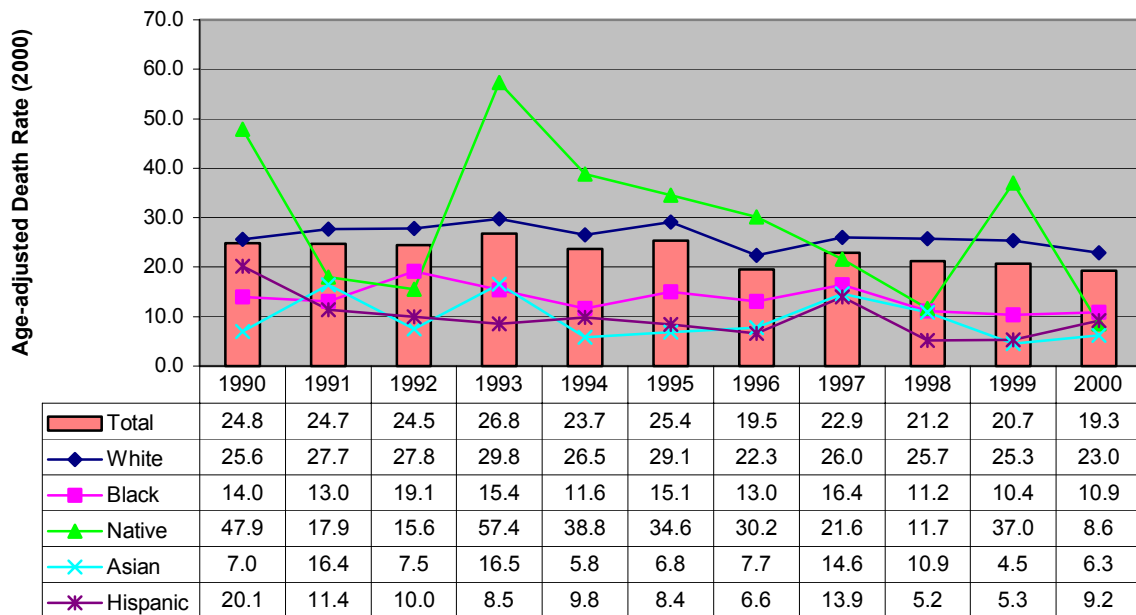


Deaths Per 100,000 Race/Ethnic Specific Population

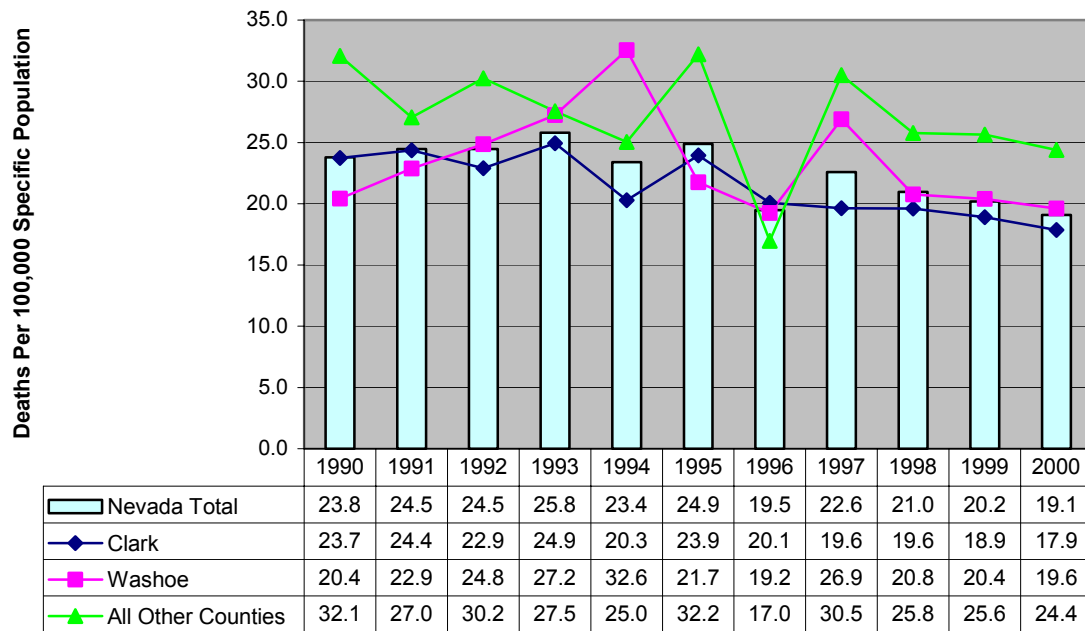
Suicide Mortality Rates by Race/Ethnicity, Nevada Residents, 1990-2000



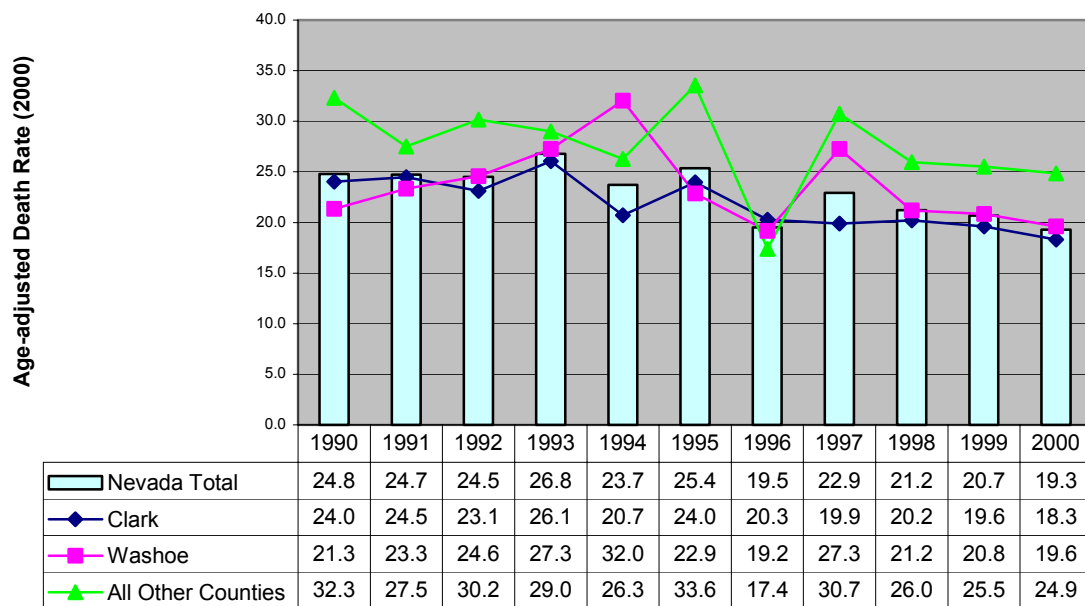
Suicide Age-Adjusted Death Rates (2000), Nevada, 1990-2000



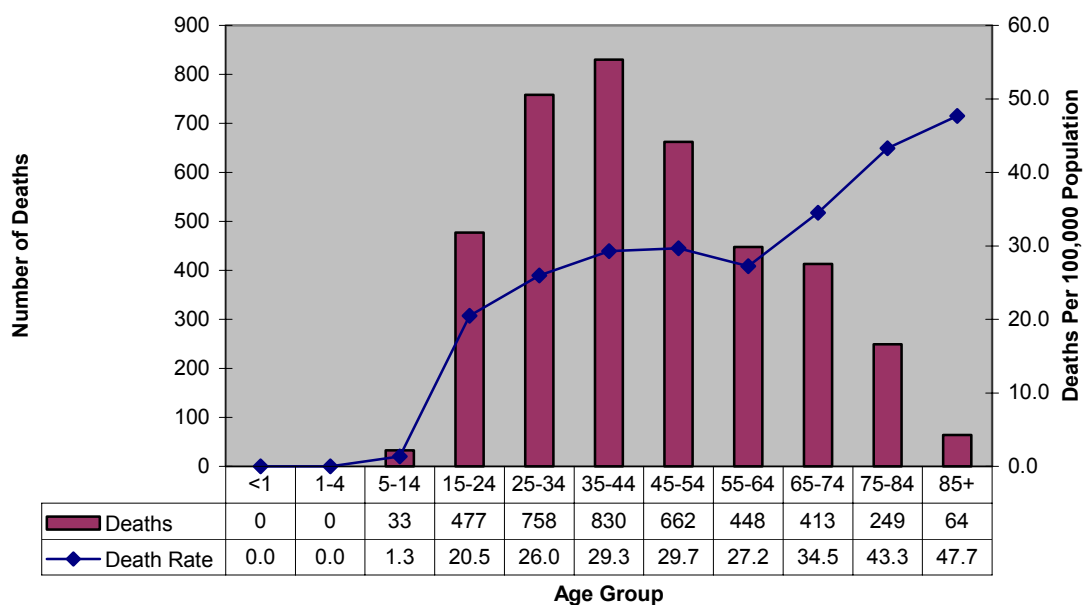
Suicide Mortality Rates by County of Residence, Nevada, 1990-2000



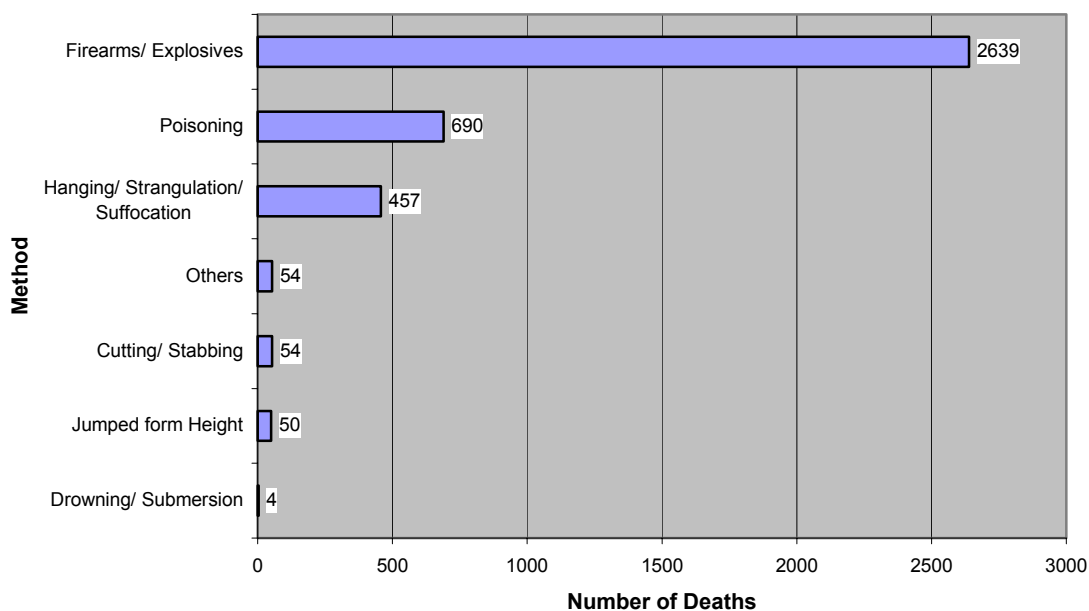
Suicide Age-Adjusted Death Rates (2000), Nevada, 1990-2000



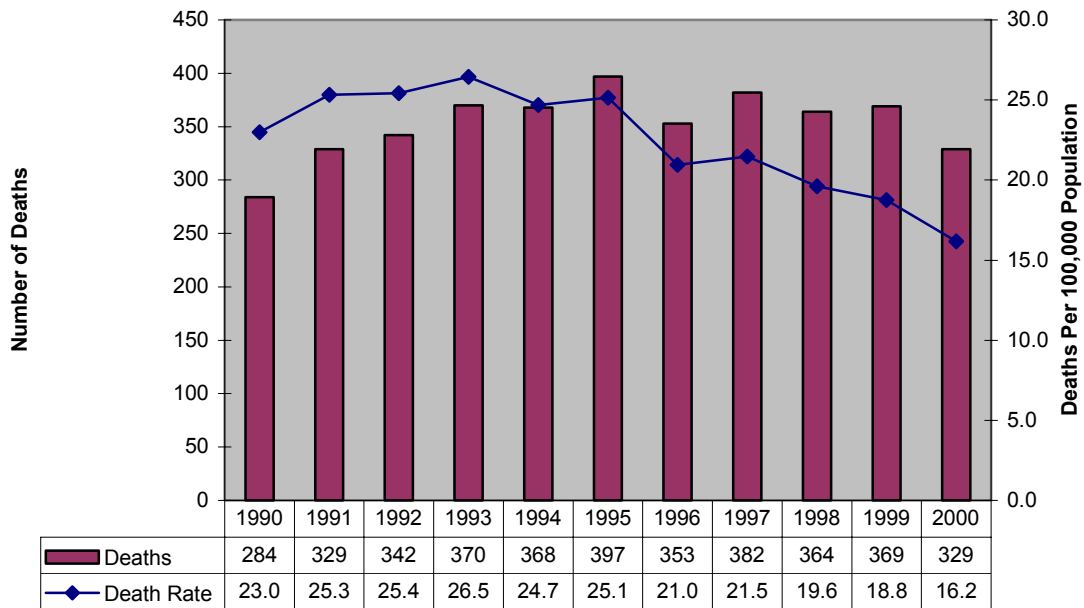
**Suicide Deaths by Age Group, Nevada Residents,
1990-2000**



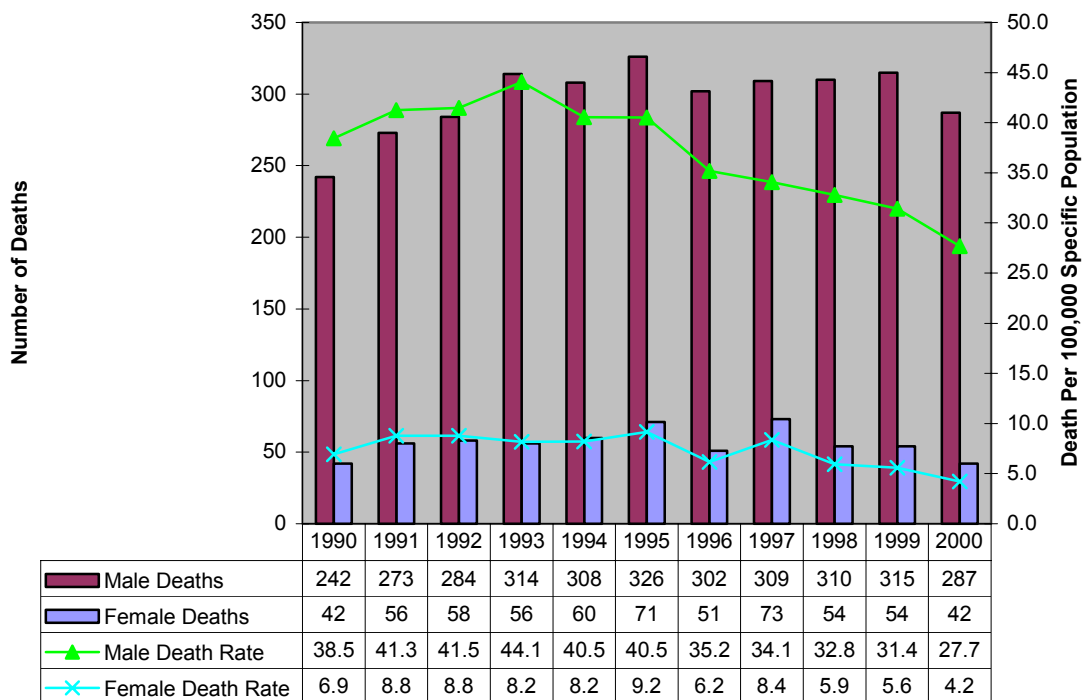
Suicide Deaths by Method, Nevada Residents, 1990-2000



Firearm Deaths by Year, Nevada Residents, 1990-2000

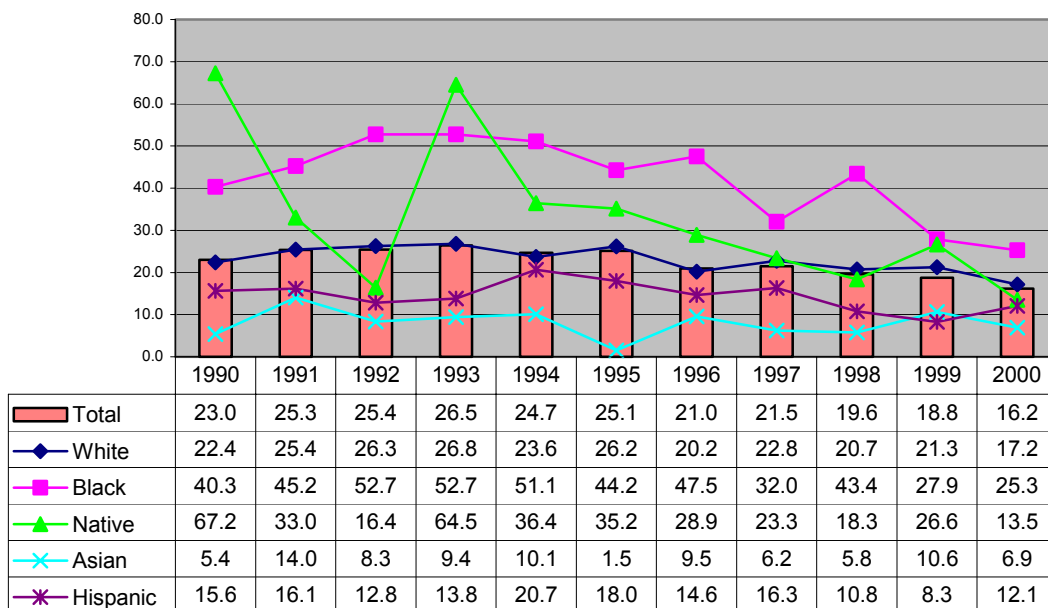


Firearm Deaths by Gender, Nevada Residents, 1990-2000

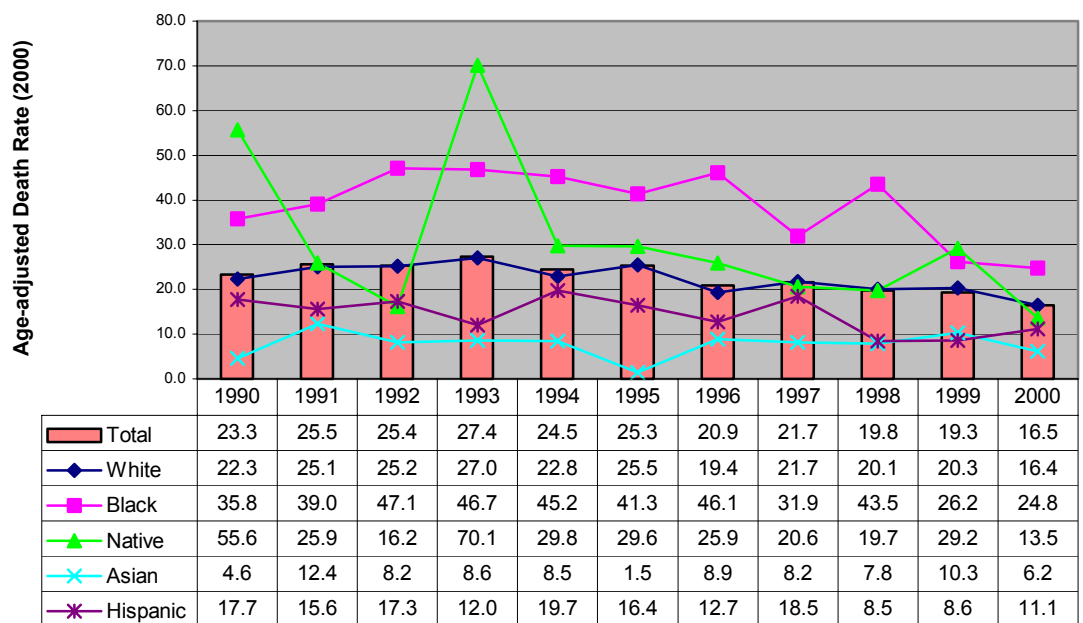


Source from Vital Records, Nevada State Health Division (NSHD), 1990-2000

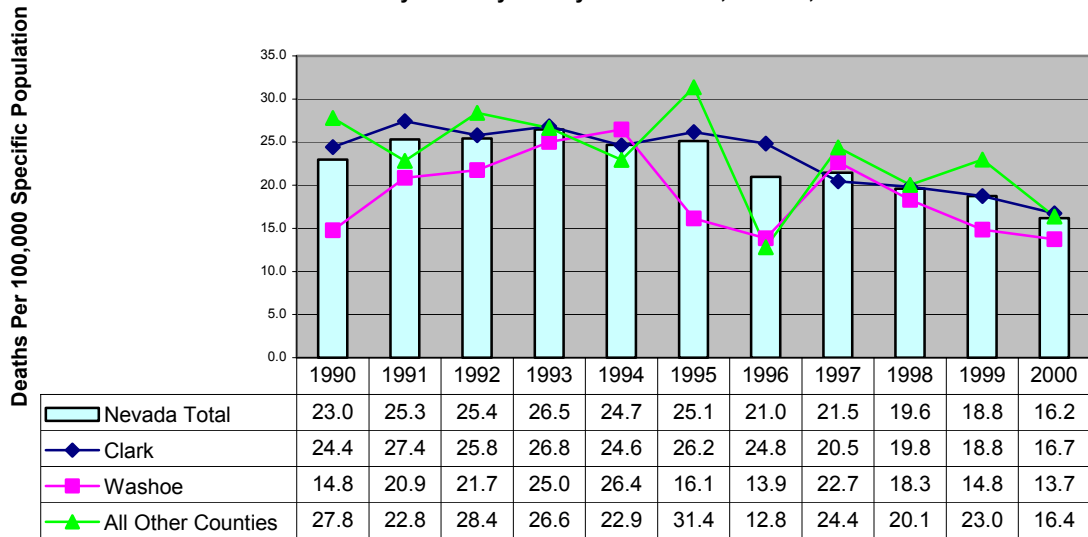
Firearm Mortality Rates By Race/Ethnicity, Nevada Residents, 1990-2000



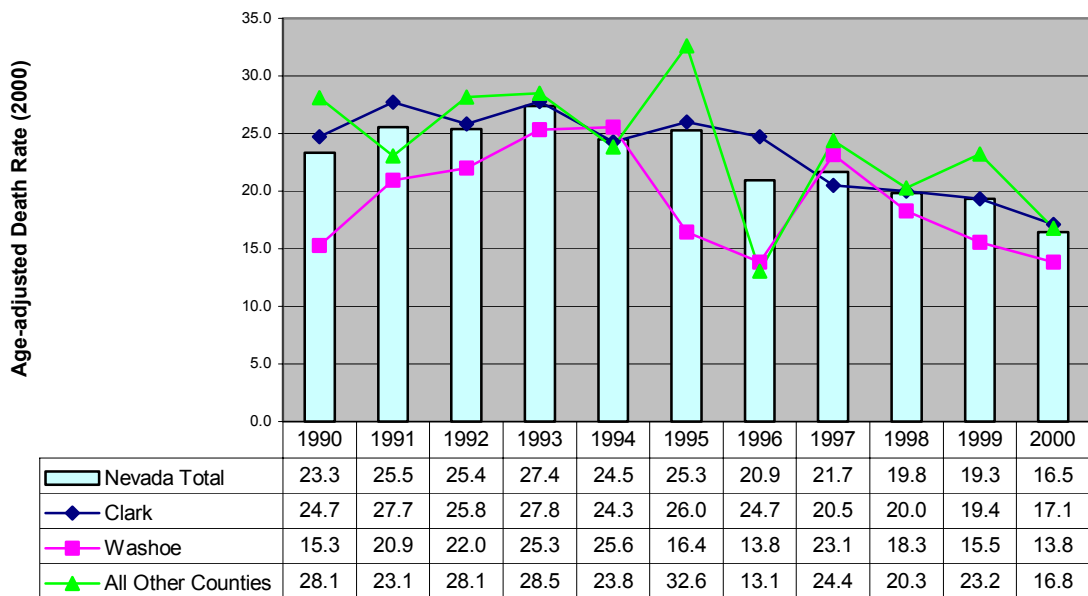
Firearm Age-Adjusted Death Rates, 1990-2000



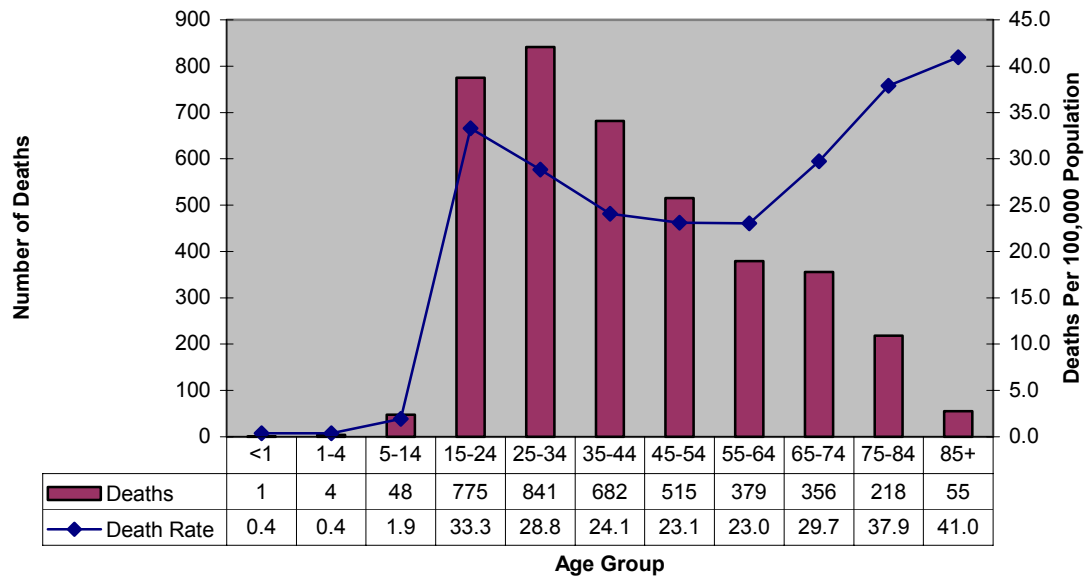
Firearm Deaths Mortality Rates By County of Residents, Nevada, 1990-2000



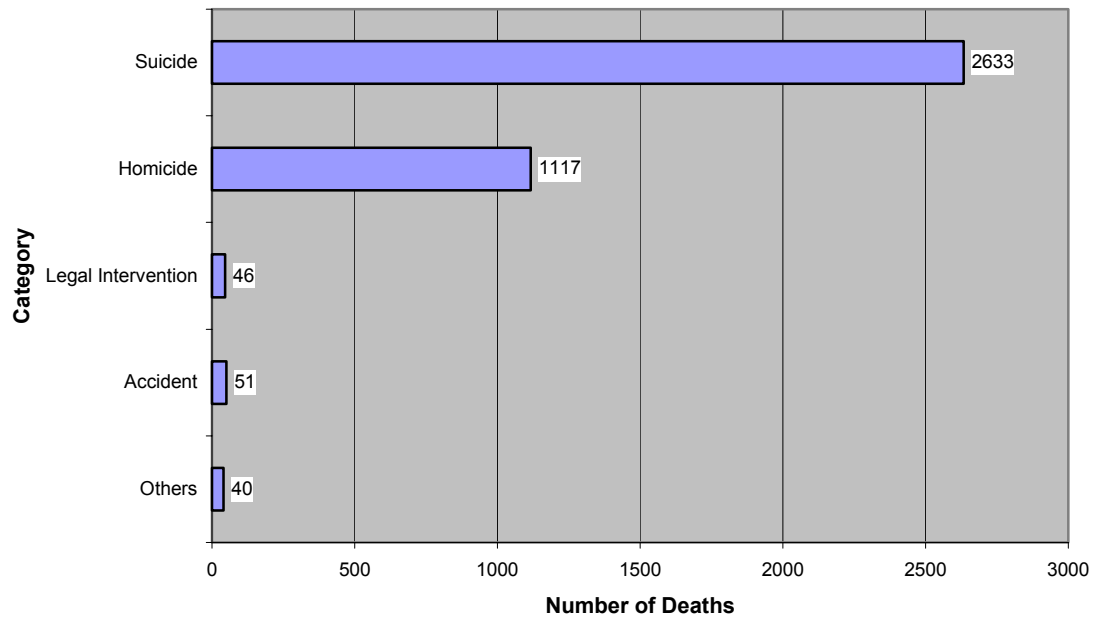
Firearm Age-Adjusted Death Rates (2000), Nevada, 1990-2000



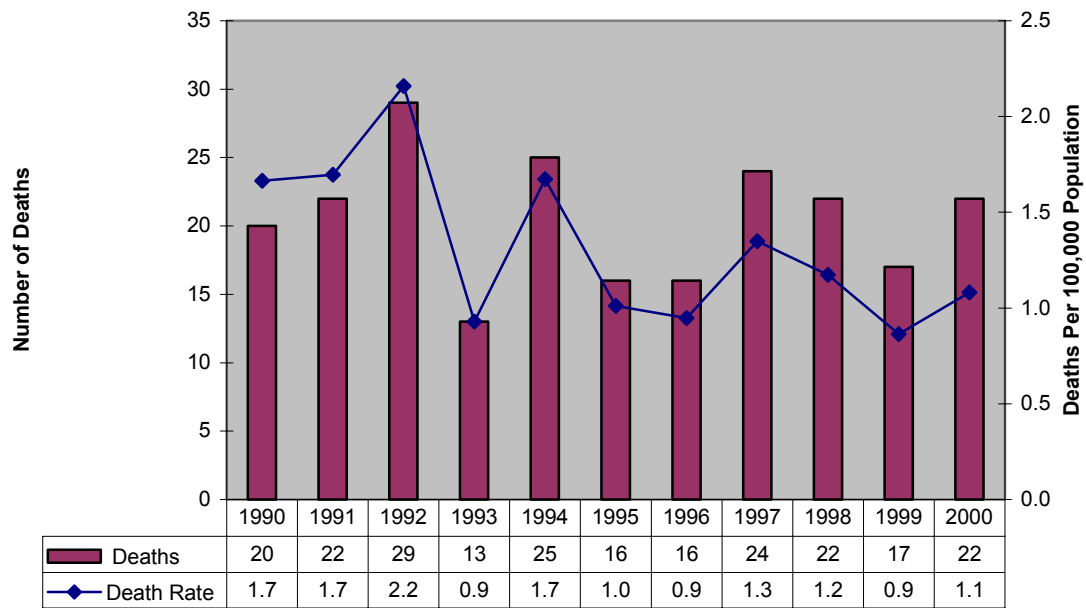
Firearm Deaths by Age Group, Nevada Residents, 1990-2000



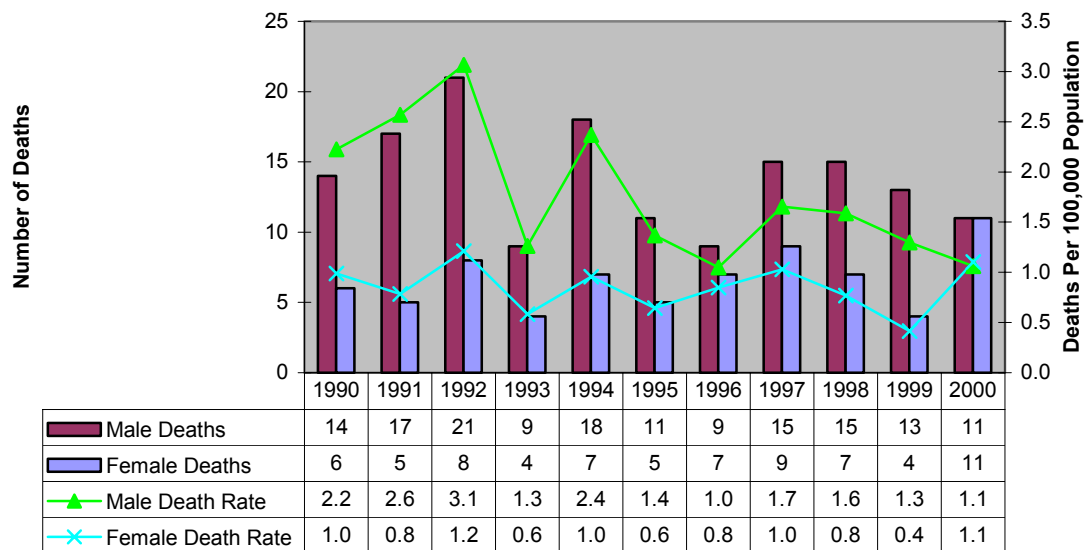
Firearm Deaths by Category, Nevada Residents, 1990-2000



Unintentional Fire and Burn Deaths by Year, Nevada Residents, 1990-2000

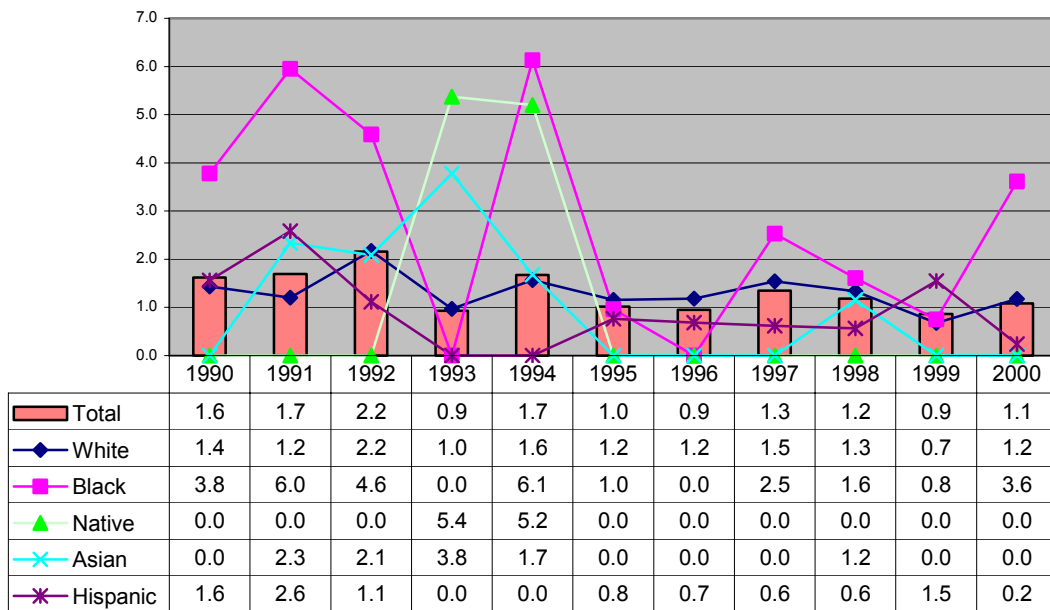


Unintentional Fire and Burn Deaths by Gender, Nevada Residents, 1990-2000

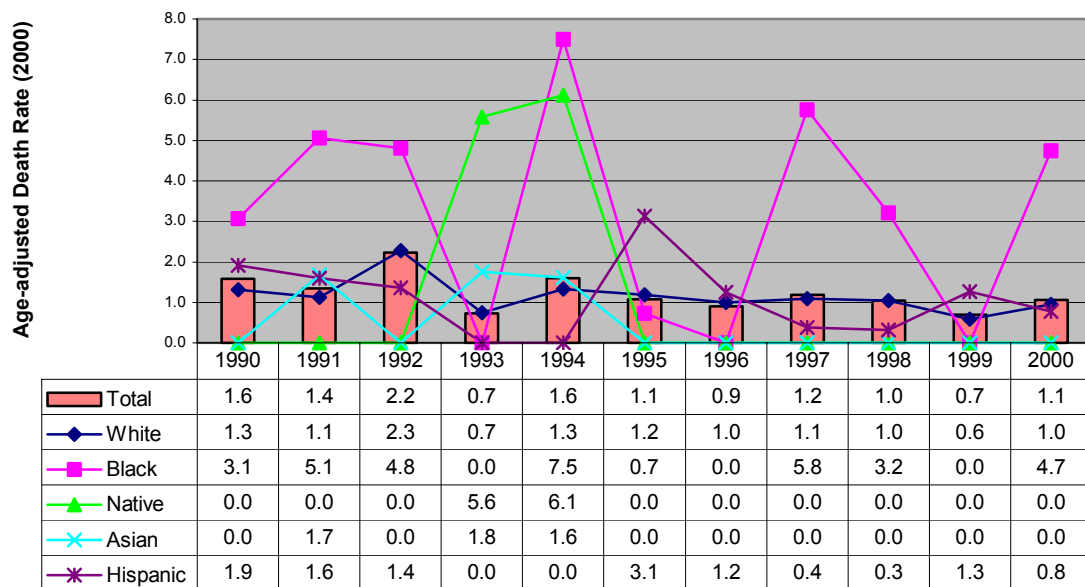


Deaths Per 100,000 Race/Ethnic Specific Population

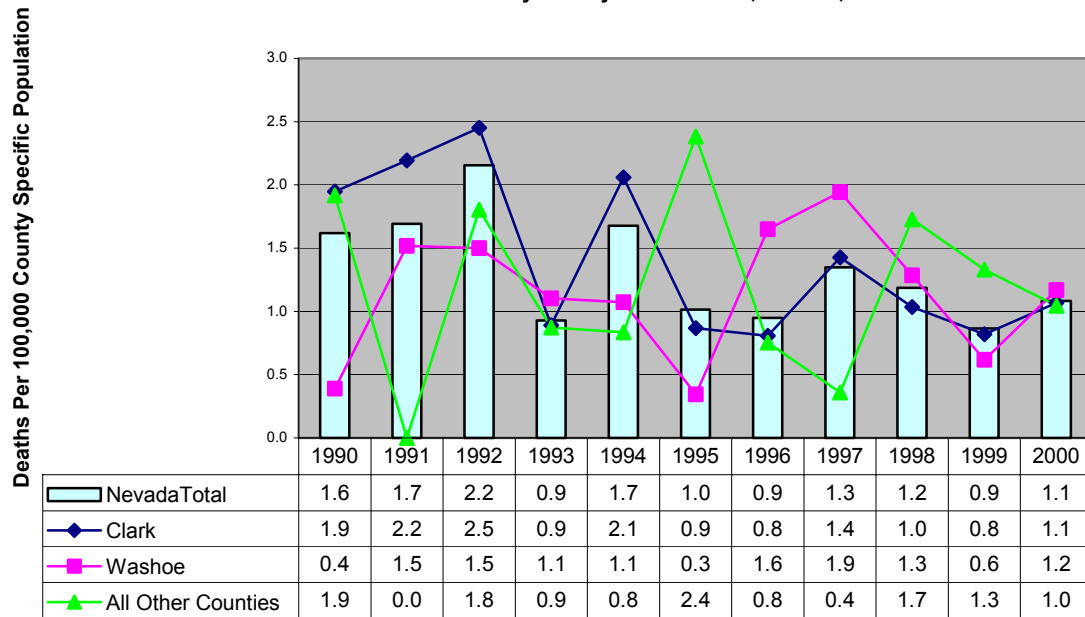
Unintentional Fire and Burn Deaths by Race/Ethnicity, Nevada Residents, 1990-2000



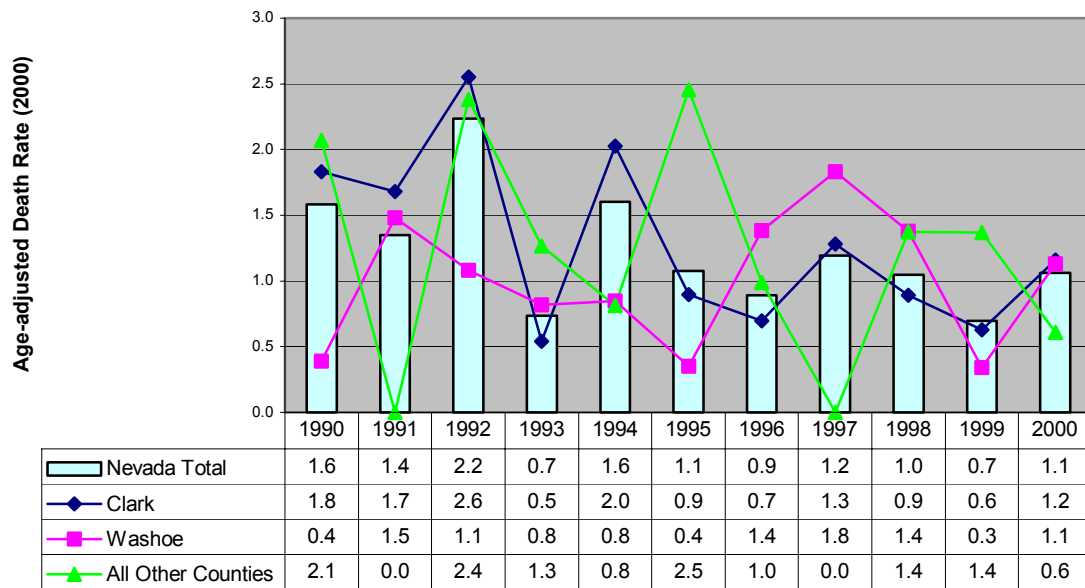
Unintentional Fire and Burn Age-Adjusted Death Rates, 1990-2000



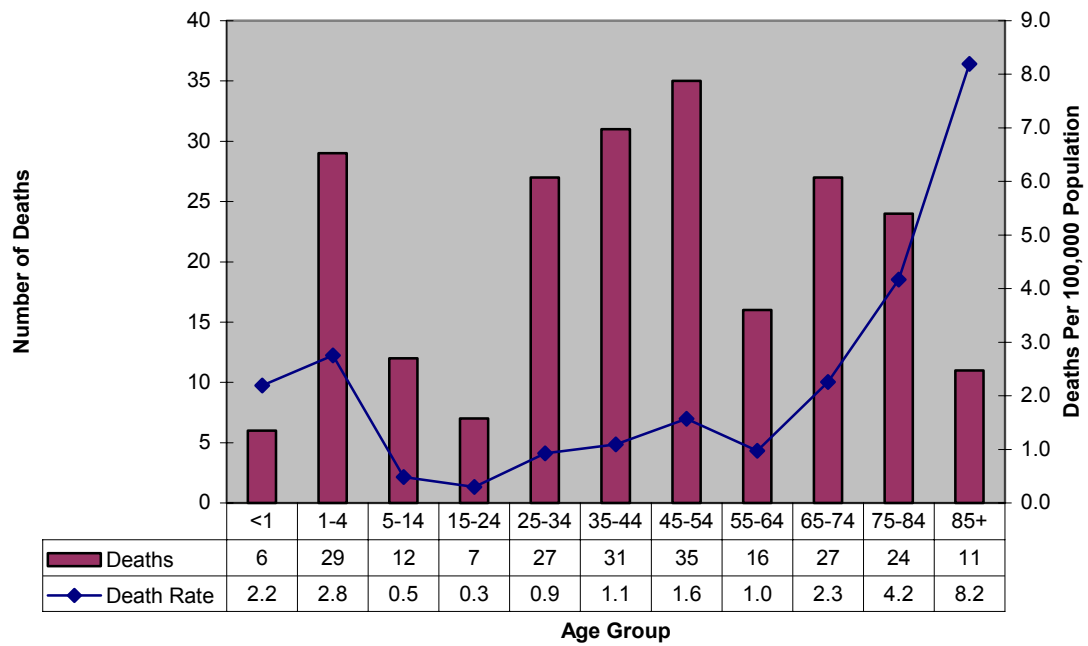
Unintentional Fire and Burn Deaths by County of Residence, Nevada, 1990-2000



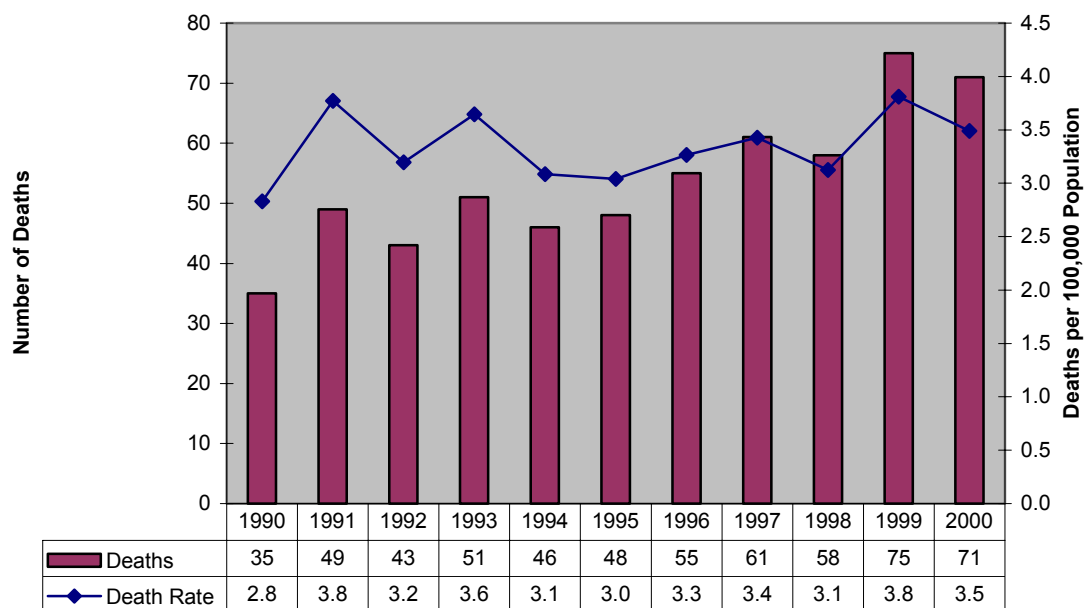
Unintentional Fire and Burn Age-Adjusted Death Rate, 1990-2000



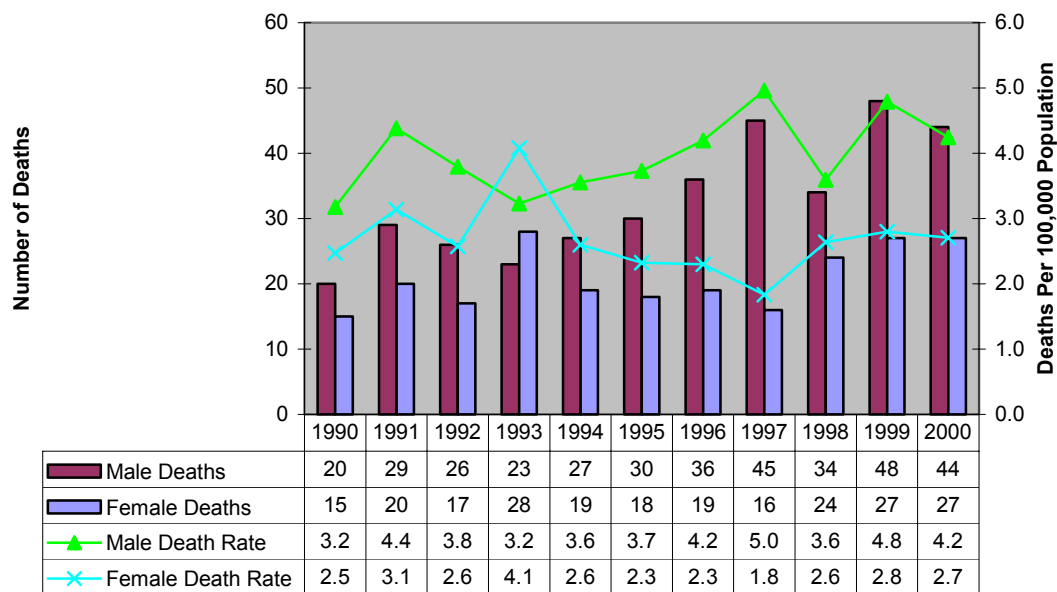
Unintentional Fire and Burn Deaths by Age Group, Nevada Residents, 1990-2000



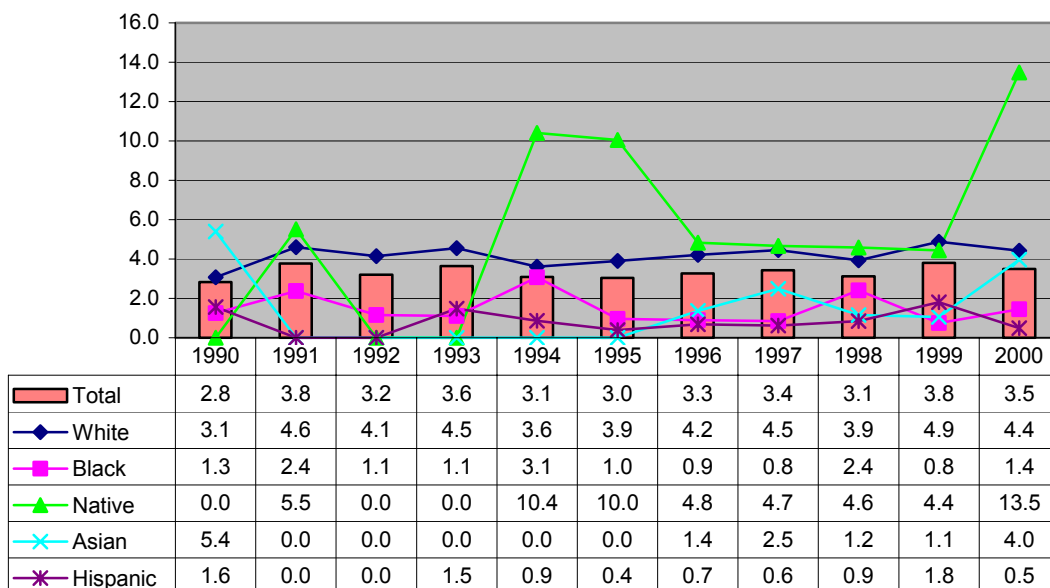
Unintentional Fall Injury Deaths by Year, Nevada Residents, 1990-2000



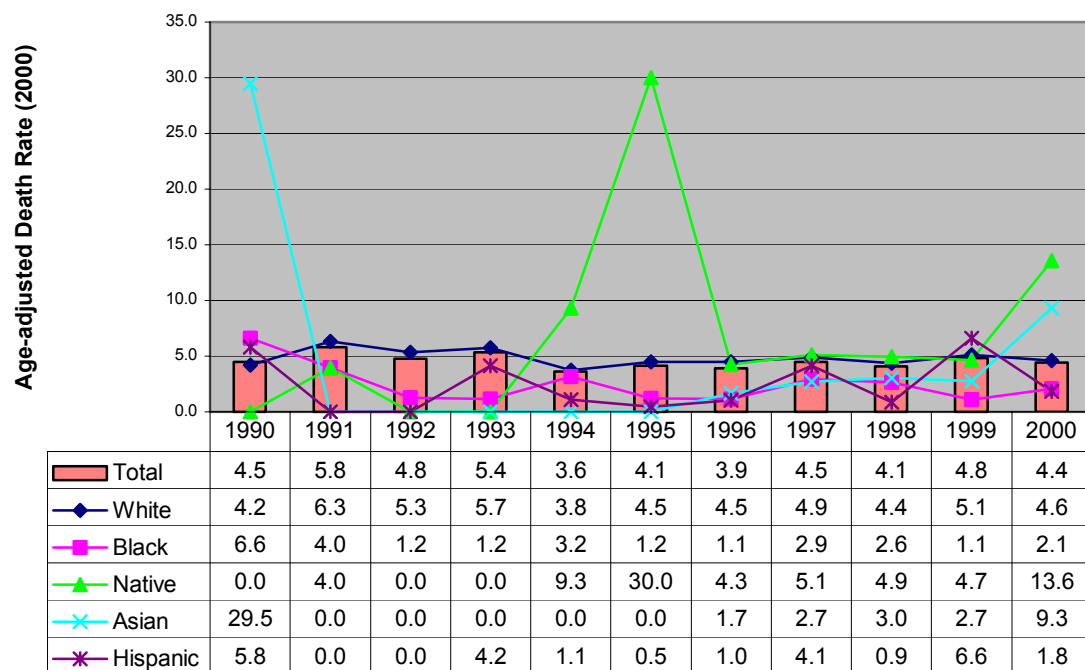
Unintentional Fall Injury Deaths by Gender, Nevada Residents, 1990-2000



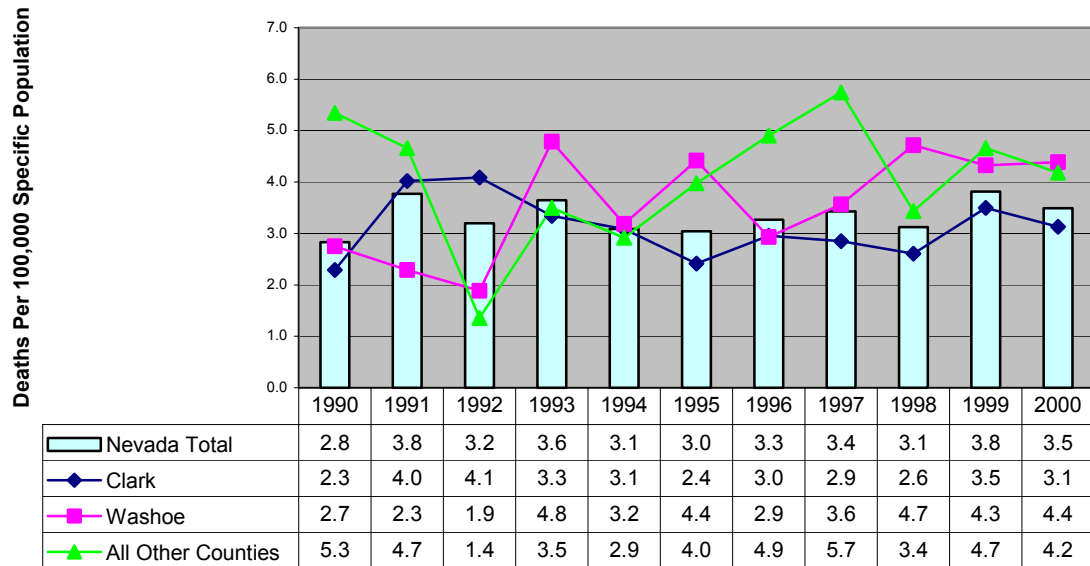
Unintentional Fall Injury Mortality Rates by Race/Ethnicity, Nevada Residents, 1990-2000



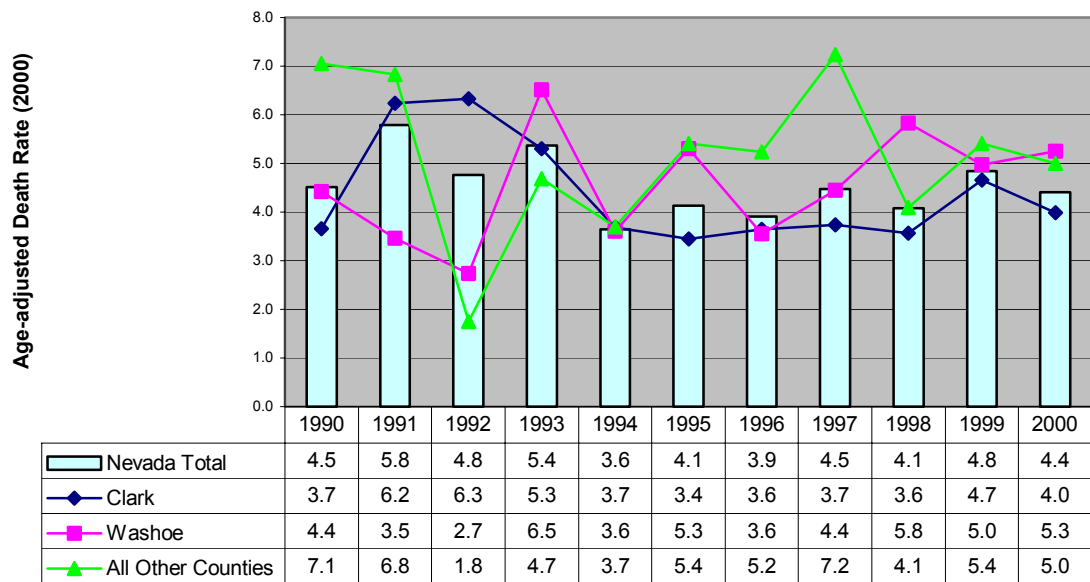
Unintentional Fall Age-Adjusted Death Rates (2000), Nevada, 1990-2000



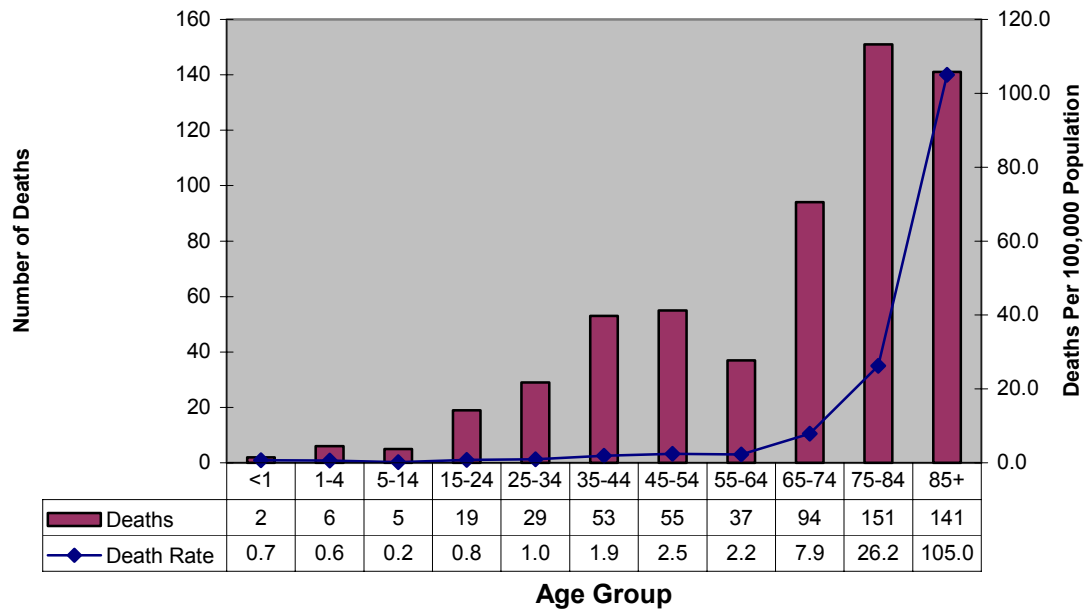
Unintentional Fall Injury Mortality Rates by County of Residence, Nevada, 1990-2000



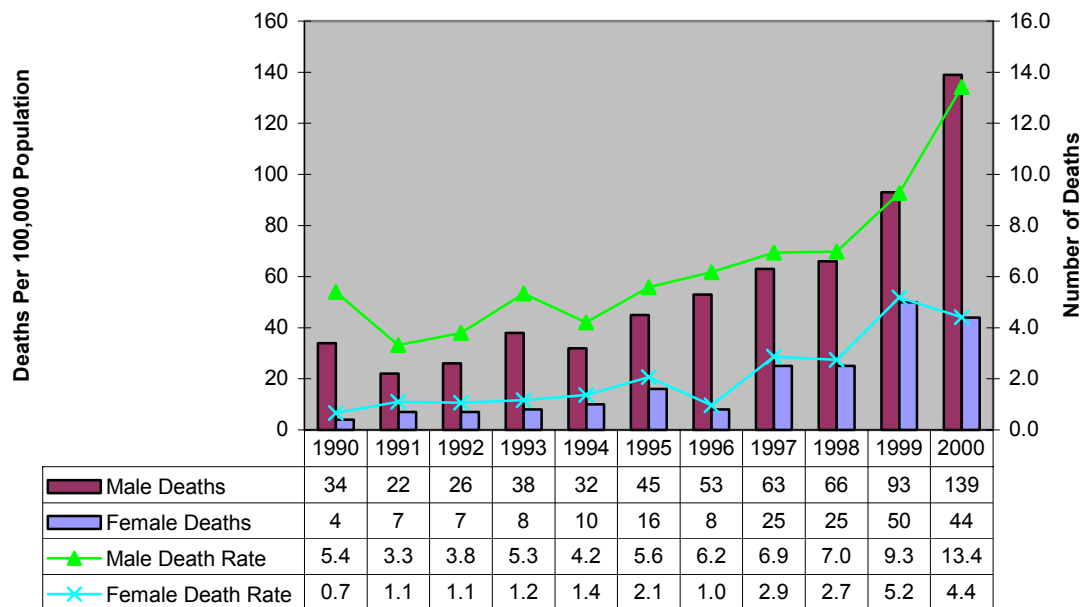
Unintentional Fall Age-Adjusted Death Rates (2000),1990-2000



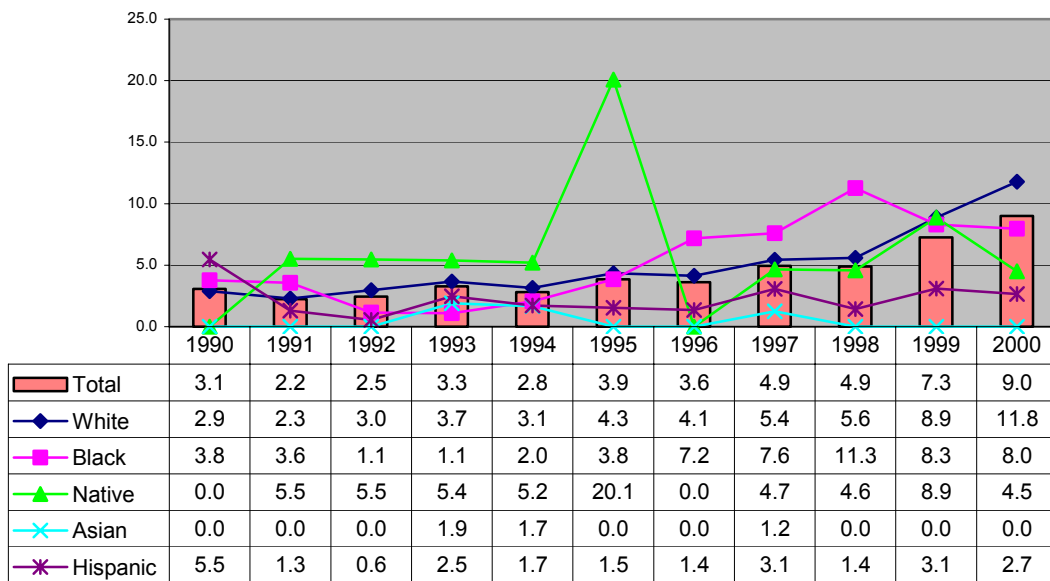
Unintentional Fall Injury Deaths by Age Group, Nevada Residents, 1990-2000



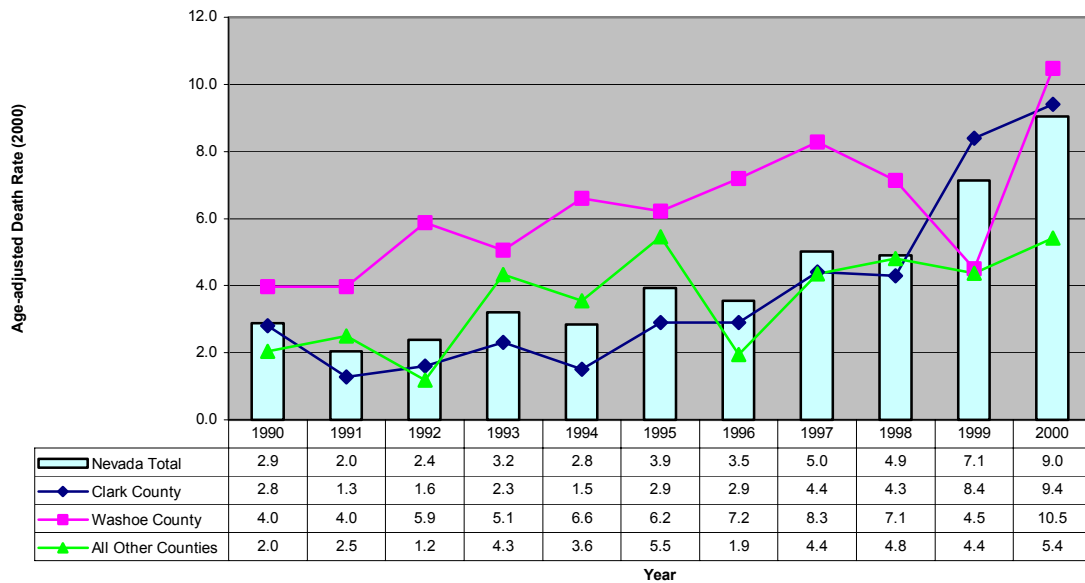
Unintentional Poisoning Deaths by Gender, Nevada Resident, 1990-2000



**Accidental Poisoning Mortality Rate by Race/Ethnicity, Nevada Residents,
1990-2000**

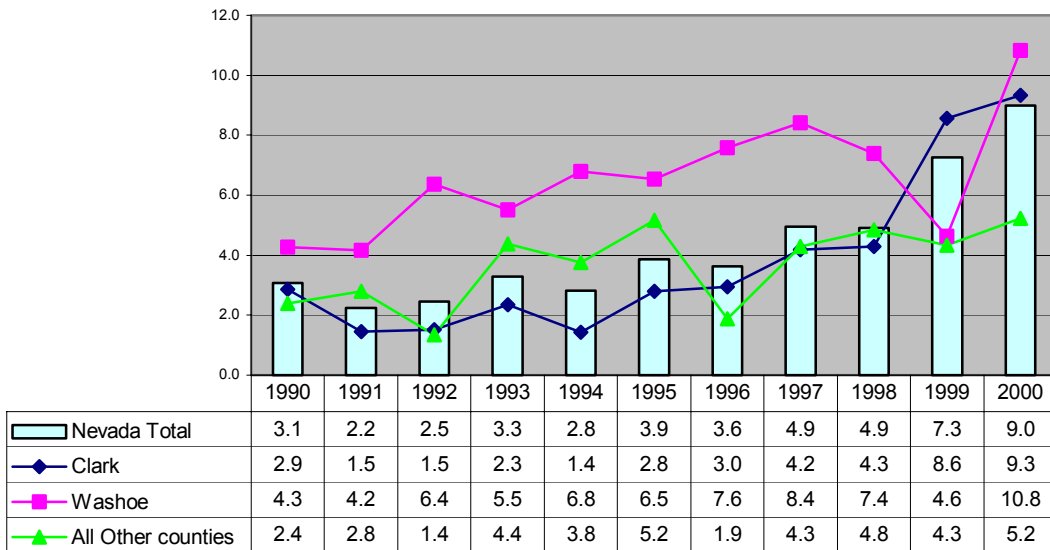


Unintentional Poisoning Age-Adjusted Death Rate, 1990-2000



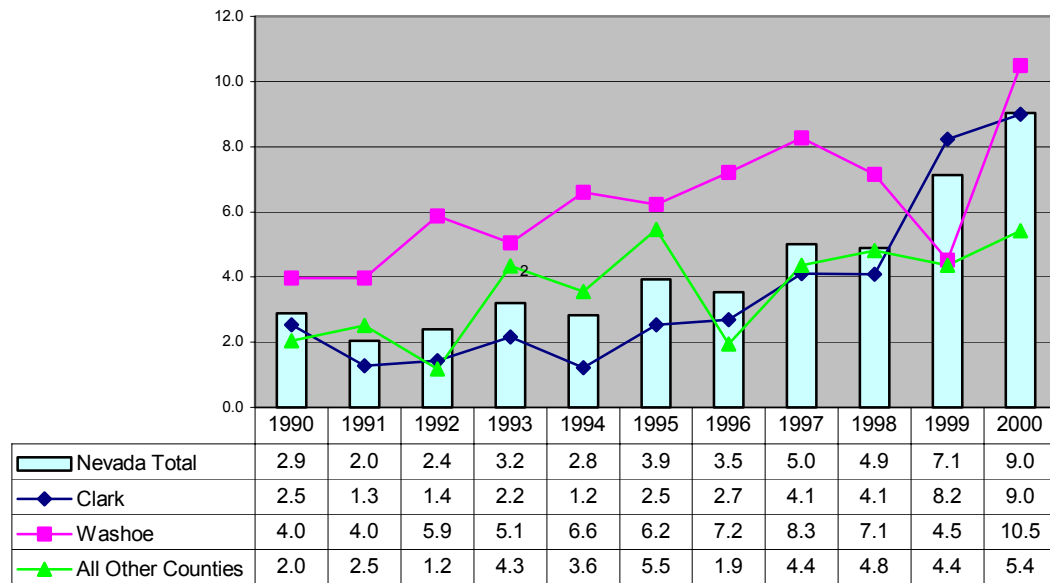
**Unintentional Poisoning Mortality Rates by County of Residence, Nevada,
1990-2000**

Deaths Per 100,000 County Specific Population

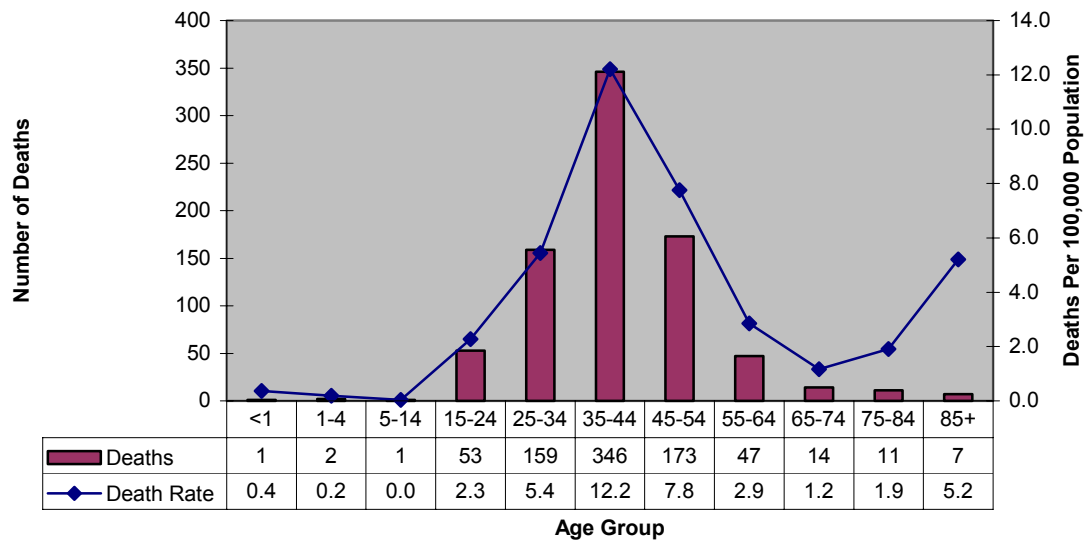


Unintentional Poisoning Age-Adjusted Death Rates (2000), 1990-2000

Age-adjusted Death Rate (2000)



Accidental Poisoning Deaths by Age Group, Nevada Residents, 1990-2000



Source from Vital Records, Nevada State Health Division (NSHD), 1990-2000

SUMMARY OF NEVADA'S INJURY STATUS AND OBJECTIVES TO BE MET
BY THE YEAR 2010

Healthy People (HP) 2010 Objective	Nevada's Current Status
HP 18-1. By 2010, the suicide rate will be reduced to 5.0 suicide deaths per 100,000 population.	<ul style="list-style-type: none"> ➤ 1998: 21.2 ➤ 1999: 20.7 ➤ 2000: 19.3
HP 15-3. By 2010, the firearm-related mortality rate will be reduced no more than 4.1 deaths per 100,000 population.	<ul style="list-style-type: none"> ➤ 1998: 19.8 ➤ 1999: 19.3 ➤ 2000: 16.5
HP 15-8. By 2010, the death rate caused by poisonings will be reduced no more than 1.5 deaths per 100,000 population.	<ul style="list-style-type: none"> ➤ 1998: 4.9 ➤ 1999: 7.1 ➤ 2000: 9.9
HP 15-19. By 2010, 92% of the total population will use the safety belts.	<ul style="list-style-type: none"> ➤ 1997: 88.5% ➤ 2001: 68.2% (9th grade-12th grade students)
HP 15-15a. By 2010, the death rate caused by Motor Vehicle crashes will be no more than 9.2 deaths per 100,000 population.	<ul style="list-style-type: none"> ➤ 1998: 17.5 ➤ 1999: 15.0 ➤ 2000: 13.2
HP 15-27. BY 2010, the death rate caused by falls will be reduced no more than 3.0 deaths per 100,000 population	<ul style="list-style-type: none"> ➤ 1998: 4.1 ➤ 1999: 4.8 ➤ 2000: 4.4
HP 15-32. Homicide will be reduced to no more than 3.0 per 100,000 population.	<ul style="list-style-type: none"> ➤ 1998: 8.9 ➤ 1999: 8.2 ➤ 2000: 6.2
HP 15-26. Residential Smoke Alarm on every floor will be increased to 100%	<ul style="list-style-type: none"> ➤ 1995: 95% ➤ 1997: 97.5% ➤ 1999: 92.2%
HP 26-6. By 2010, reduce the proportion of adolescents who report that they rode, during, the previous 30 days, with a driver who had been drinking alcohol to no more than 30%	<ul style="list-style-type: none"> ➤ 2001: 29.9% (9th grade- 12 grade students) <p style="margin-left: 40px;">* Objective achieved</p>

Conclusion

The Nevada State Health Division believes that the information that is provided in this report will help the reader move injury prevention efforts forward an additional step. At a minimum:

- Implement interventions that we know can work, adapting them for local application as appropriate.
- Tackle under addressed areas of injury prevention, such as suicide and drownings.
- Improve our approaches with hard-to-reach high-risk populations.
- Integrate injury prevention more fully into the rest of public health.
- Bridge the gap between injury prevention research and practice.
- Constantly seek increases in injury prevention funding and support.

As long as injury prevention continues to move forward, ever expanding and improving its impact, we may be optimistic that injury, this leading public health problem, will be brought increasingly under control. After all, it is because the infectious diseases of the past have been effectively brought under control with the tools of public health that injury has moved into the lead as the number one cause of productive years of life lost in the United States (CDC). The public health approach, so effective with infectious diseases, can be used to reduce injury, protecting the public from a preventable source of mortality, morbidity, and misery. This is what public health is all about, a challenge and a cause that carries with it the potential to help create a safer better, and more satisfying world.

